



Facility Name & ID Number South Shore Nsg & Rehab Ctr

# 0042119 Report Period Beginning: 01/01/09 Ending: 12/31/09

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>240</u>	Skilled (SNF)	<u>240</u>	<u>87,600</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>240</u>	TOTALS	<u>240</u>	<u>87,600</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF	<u>55,824</u>	<u>2,156</u>	<u>7,120</u>	<u>65,100</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>55,824</u>	<u>2,156</u>	<u>7,120</u>	<u>65,100</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.32%

D. How many bed-hold days during this year were paid by the Department? 49 (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 5/28/98

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 5/28/98 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 240 and days of care provided 7,021

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/09 Ending: 12/31/09

**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
	<b>A. General Services</b>										
1	Dietary	463,174	78,132	14,221	555,527		555,527	(2,198)	553,329		1
2	Food Purchase		349,526		349,526		349,526	596	350,122		2
3	Housekeeping	273,625	82,212		355,837		355,837	(6,303)	349,534		3
4	Laundry	154,587	38,758		193,345		193,345	(974)	192,371		4
5	Heat and Other Utilities			317,824	317,824		317,824	3,279	321,103		5
6	Maintenance	114,614		289,633	404,247		404,247	13,834	418,081		6
7	Other (specify):*							2,717	2,717		7
8	<b>TOTAL General Services</b>	<b>1,006,000</b>	<b>548,628</b>	<b>621,678</b>	<b>2,176,306</b>		<b>2,176,306</b>	<b>10,951</b>	<b>2,187,257</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			29,000	29,000		29,000		29,000		9
10	Nursing and Medical Records	3,541,071	199,557	99,357	3,839,985		3,839,985	21,833	3,861,818		10
10a	Therapy	209,993			209,993		209,993	2,176	212,169		10a
11	Activities	173,274	4,270		177,544		177,544		177,544		11
12	Social Services	145,470		9,273	154,743		154,743	11,680	166,423		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							23,110	23,110		15
16	<b>TOTAL Health Care and Programs</b>	<b>4,069,808</b>	<b>203,827</b>	<b>137,630</b>	<b>4,411,265</b>		<b>4,411,265</b>	<b>58,799</b>	<b>4,470,064</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	137,968		27,600	165,568		165,568	50,591	216,159		17
18	Directors Fees										18
19	Professional Services			604,939	604,939		604,939	(508,728)	96,211		19
20	Dues, Fees, Subscriptions & Promotions			58,491	58,491		58,491	(6,703)	51,788		20
21	Clerical & General Office Expenses	83,866	32,041	1,219,268	1,335,175		1,335,175	(874,013)	461,162		21
22	Employee Benefits & Payroll Taxes			1,018,092	1,018,092		1,018,092	(33,200)	984,892		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,659	8,659		8,659	1,365	10,024		24
25	Other Admin. Staff Transportation			1,490	1,490		1,490	804	2,294		25
26	Insurance-Prop.Liab.Malpractice			498,135	498,135		498,135	2,001	500,136		26
27	Other (specify):*							47,472	47,472		27
28	<b>TOTAL General Administration</b>	<b>221,834</b>	<b>32,041</b>	<b>3,436,674</b>	<b>3,690,549</b>		<b>3,690,549</b>	<b>(1,320,411)</b>	<b>2,370,138</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>5,297,642</b>	<b>784,496</b>	<b>4,195,982</b>	<b>10,278,120</b>		<b>10,278,120</b>	<b>(1,250,661)</b>	<b>9,027,459</b>		<b>29</b>

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number South Shore Nsg & Rehab Ctr

#0042119

Report Period Beginning:

01/01/09

Ending:

12/31/09

## 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	
	<b>D. Ownership</b>											
30	Depreciation			116,109	116,109		116,109	329,863	445,972			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			39,501	39,501		39,501	672,865	712,366			32
33	Real Estate Taxes			315,072	315,072		315,072	2,922	317,994			33
34	Rent-Facility & Grounds			1,164,000	1,164,000		1,164,000	(1,155,905)	8,095			34
35	Rent-Equipment & Vehicles			13,281	13,281		13,281	3,266	16,547			35
36	Other (specify):*							38,710	38,710			36
37	<b>TOTAL Ownership</b>			1,647,963	1,647,963		1,647,963	(108,279)	1,539,684			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		544,665	756,905	1,301,570		1,301,570	(53,632)	1,247,938			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			131,400	131,400		131,400		131,400			42
43	Other (specify):*			305	305		305	(305)				43
44	<b>TOTAL Special Cost Centers</b>		544,665	888,610	1,433,275		1,433,275	(53,937)	1,379,338			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,297,642	1,329,161	6,732,555	13,359,358		13,359,358	(1,412,876)	11,946,482			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

**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	15,336	30		9
10	Interest and Other Investment Income	(54,500)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(116)	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	(43,779)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(831,987)	21		24
25	Fund Raising, Advertising and Promotional	(8,515)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(784)	20		28
29	Other-Attach Schedule	(249,315)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (1,173,660)		\$	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)	(239,217)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (239,217)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,412,876)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

South Shore Nsg & Rehab Ctr

ID# 0042119

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Patient Clothing	\$ (1,170)	10	1
2	Theft Loss	(609)	21	2
3	Collections Expense	(4,488)	21	3
4	Miscellaneous Income	(659)	21	4
5	Capitalized R&M	(2,788)	06	5
6	Secretary of State - Annual Report	(250)	20	6
7	Non-Allowable Management Fees	(164,400)	21	7
8	Prior Period Adjustment - Computer Expense	(27,045)	21	8
9	Non-Allowable Legal Fees	(23,091)	19	9
10	Building Co - Trust Fees	(150)	21	10
11	Building Co - Filing Fees	(250)	21	11
12	Building Co - Bank Charges	(112)	21	12
13	Non-Allowable Management Fees	(24,000)	17	13
14	Marketing Expense	(305)	43	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	<b>Total</b>	(249,315)		49

South Shore Nsg & Rehab Ctr

ID# 0042119

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line 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 South Shore Nsg & Rehab Ctr# 0042119

Report Period Beginning:

01/01/09

Ending:

12/31/09

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			320		5,559	(63)			(8,014)			(2,198)	1
2	Food Purchase	(116)		712									596	2
3	Housekeeping			665		73	(7,041)						(6,303)	3
4	Laundry						(974)						(974)	4
5	Heat and Other Utilities			2,727		175				377			3,279	5
6	Maintenance	(2,788)		4,233	10,369	23	(55)		1,764	288			13,834	6
7	Other (specify):*				1,911	806							2,717	7
8	<b>TOTAL General Services</b>	<b>(2,904)</b>		<b>8,657</b>	<b>12,280</b>	<b>6,636</b>	<b>(8,133)</b>		<b>1,764</b>	<b>(7,349)</b>			<b>10,951</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(1,170)				37,842	(14,840)						21,833	10
10a	Therapy					2,176							2,176	10a
11	Activities													11
12	Social Services					11,704	(24)						11,680	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					23,110							23,110	15
16	<b>TOTAL Health Care and Programs</b>	<b>(1,170)</b>				<b>74,832</b>	<b>(14,863)</b>						<b>58,799</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(24,000)		3,122	11,321	49,361				10,787			50,591	17
18	Directors Fees													18
19	Professional Services	(23,091)		(355,170)		(130,966)			97	402			(508,728)	19
20	Fees, Subscriptions & Promotions	(9,549)		2,672		10				164			(6,703)	20
21	Clerical & General Office Expenses	(1,073,478)	512	21,872	170,276	11,069			(17,319)	13,055			(874,013)	21
22	Employee Benefits & Payroll Taxes				(11,621)	(21,145)	(434)						(33,200)	22
23	Inservice Training & Education													23
24	Travel and Seminar			84		1,281							1,365	24
25	Other Admin. Staff Transportation			488					8	308			804	25
26	Insurance-Prop.Liab.Malpractice			1,072		63			100	766			2,001	26
27	Other (specify):*				34,188	8,576				4,708			47,472	27
28	<b>TOTAL General Administration</b>	<b>(1,130,117)</b>	<b>512</b>	<b>(325,860)</b>	<b>204,164</b>	<b>(81,751)</b>	<b>(434)</b>		<b>(17,114)</b>	<b>30,190</b>			<b>(1,320,411)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(1,134,191)</b>	<b>512</b>	<b>(317,203)</b>	<b>216,444</b>	<b>(283)</b>	<b>(23,431)</b>		<b>(15,350)</b>	<b>22,841</b>			<b>(1,250,661)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number South Shore Nsg & Rehab Ctr# 0042119

Report Period Beginning:

01/01/09

Ending:

12/31/09

## 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	15,336	288,253	5,467		1,210			18,809	788			329,863	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(54,500)	629,043	80,354		14,625			3,343				672,865	32
33	Real Estate Taxes			2,636		286							2,922	33
34	Rent-Facility & Grounds		(1,164,000)	4,572						3,523			(1,155,905)	34
35	Rent-Equipment & Vehicles			3,229						37			3,266	35
36	Other (specify):*		38,710										38,710	36
37	<b>TOTAL Ownership</b>	<b>(39,164)</b>	<b>(207,994)</b>	<b>96,258</b>		<b>16,121</b>			<b>22,152</b>	<b>4,348</b>			<b>(108,279)</b>	37
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(7,344)		(17,925)	(28,363)			(53,632)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(305)											(305)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(305)</b>					<b>(7,344)</b>		<b>(17,925)</b>	<b>(28,363)</b>			<b>(53,937)</b>	44
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(1,173,660)	(207,482)	(220,945)	216,444	15,838	(30,775)		(11,123)	(1,174)			(1,412,876)	45

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				South Shore Property, LLC		Building Co.

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 1,164,000	South Shore Property, LLC	100.00%	\$	(1,164,000)	1
2	V	32 Interest	263,726	South Shore Property, LLC	100.00%	892,769	629,043	2
3	V	21 Bank Charges		South Shore Property, LLC	100.00%	112	112	3
4	V	21 Trust Fees		South Shore Property, LLC	100.00%	150	150	4
5	V	21 Filing Fees		South Shore Property, LLC	100.00%	250	250	5
6	V	30 Depreciation Expense		South Shore Property, LLC	100.00%	288,253	288,253	6
7	V	36 Amortization Expense		South Shore Property, LLC	100.00%	38,710	38,710	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,427,726			\$ 1,220,244	\$ * (207,482)	14

\* 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	01 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 320	\$	320	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	712		712	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	665		665	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	2,727		2,727	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	4,233		4,233	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	3,122		3,122	20
21	V	19 Professional Fees	368,676	Extended Care Consulting, LLC	100.00%	13,506		(355,170)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	2,672		2,672	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	21,872		21,872	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	84		84	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	488		488	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	1,072		1,072	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	5,467		5,467	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	80,354		80,354	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	2,636		2,636	29
30	V	34 Rent - Building		Extended Care Consulting, LLC	100.00%	4,572		4,572	30
31	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	3,229		3,229	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 368,676			\$ 147,731	\$ *	(220,945)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	06 Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	10,369	\$	10,369	15
16	V	06 Maintenance (Direct)	1,532	Extended Care Consulting, LLC	100.00%	1,532			16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,774		1,774	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	137		137	18
19	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	11,321		11,321	19
20	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	170,276		170,276	20
21	V	21 Office and Clerical (Direct)	56,572	Extended Care Consulting, LLC	100.00%	56,572			21
22	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	29,134		29,134	22
23	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	5,054		5,054	23
24	V	22 Employee Benefits	11,621	Extended Care Consulting, LLC	100.00%			(11,621)	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		\$ 69,725			\$ 286,169	\$ *	216,444	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	03 Housekeeping	\$	Extended Care Clinical, LLC	100.00%	\$ 73	\$	73	15
16	V	05 Utilities		Extended Care Clinical, LLC	100.00%	175		175	16
17	V	06 Maintenance		Extended Care Clinical, LLC	100.00%	23		23	17
18	V	19 Professional Fees	132,485	Extended Care Clinical, LLC	100.00%	1,519		(130,966)	18
19	V	20 Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	10		10	19
20	V	21 Office & Clerical		Extended Care Clinical, LLC	100.00%	1,291		1,291	20
21	V	24 Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,281		1,281	21
22	V	26 Insurance		Extended Care Clinical, LLC	100.00%	63		63	22
23	V	30 Depreciation		Extended Care Clinical, LLC	100.00%	1,210		1,210	23
24	V	32 Interest		Extended Care Clinical, LLC	100.00%	14,625		14,625	24
25	V	33 Real Estate Taxes		Extended Care Clinical, LLC	100.00%	286		286	25
26	V	01 Dietary Salary		Extended Care Clinical, LLC	100.00%	5,559		5,559	26
27	V	07 Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	806		806	27
28	V	10 Nursing Salary	96,454	Extended Care Clinical, LLC	100.00%	134,296		37,842	28
29	V	10a Rehab Salary		Extended Care Clinical, LLC	100.00%	2,176		2,176	29
30	V	12 Social Service Salary	9,273	Extended Care Clinical, LLC	100.00%	20,977		11,704	30
31	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	23,110		23,110	31
32	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	49,361		49,361	32
33	V	21 Office Salary		Extended Care Clinical, LLC	100.00%	9,778		9,778	33
34	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	8,576		8,576	34
35	V	22 Employee Benefits	21,145	Extended Care Clinical, LLC	100.00%			(21,145)	35
36	V								36
37	V								37
38	V								38
39	Total		\$ 259,357			\$ 275,195	\$ *	15,838	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$ 691	Xcel Supply, LLC	100.00%	\$ 627	\$ (63)
16	V	3 Housekeeping	76,671	Xcel Supply, LLC	100.00%	69,630	(7,041)
17	V	4 Laundry	10,603	Xcel Supply, LLC	100.00%	9,629	(974)
18	V	6 Repairs & Maintenance	600	Xcel Supply, LLC	100.00%	545	(55)
19	V	10 Nursing	161,595	Xcel Supply, LLC	100.00%	146,755	(14,840)
20	V	11 Activities		Xcel Supply, LLC	100.00%		
21	V	12 Social Service	257	Xcel Supply, LLC	100.00%	234	(24)
22	V	20 Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%		
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%		
24	V	22 Employee Benefits	4,731	Xcel Supply, LLC	100.00%	4,296	(434)
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%		
26	V	39 Ancillary	79,972	Xcel Supply, LLC	100.00%	72,628	(7,344)
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 335,119			\$ 304,344	\$ * (30,775)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 127,204	\$ 127,204	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	127,204	CCS Employee Benefits Group	100.00%		(127,204)	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		\$ 127,204			\$ 127,204	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	06 Repairs	\$	Vent Lease, LLC.	100.00%	\$ 1,764	\$ 1,764
16	V	19 Professional Fees		Vent Lease, LLC.	100.00%	97	97
17	V	21 Office and Clerical		Vent Lease, LLC.	100.00%	150	150
18	V	25 Auto Expense / Travel		Vent Lease, LLC.	100.00%	8	8
19	V	26 Insurance		Vent Lease, LLC.	100.00%	100	100
20	V	30 Depreciation		Vent Lease, LLC.	100.00%	4,590	4,590
21	V	32 Interest		Vent Lease, LLC.	100.00%	773	773
22	V	30 Depreciation - Matrix		Vent Lease, LLC.	100.00%	14,219	14,219
23	V	32 Interest - Matrix		Vent Lease, LLC.	100.00%	2,570	2,570
24	V	21 Office and Clerical	17,469	Vent Lease, LLC.	100.00%		(17,469)
25	V	39 Ancillary	17,925	Vent Lease, LLC.	100.00%		(17,925)
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 35,394			\$ 24,271	\$ * (11,123)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	01 Dietary	\$	Care Centers Health Systems, Inc.	100.00%	\$ 4,967	\$ 4,967
16	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%		
17	V	05 Heat and Other Utilities		Care Centers Health Systems, Inc.	100.00%	377	377
18	V	06 Maintenance		Care Centers Health Systems, Inc.	100.00%	288	288
19	V	19 Professional Fees		Care Centers Health Systems, Inc.	100.00%	402	402
20	V	20 Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	164	164
21	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	2,042	2,042
22	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	308	308
23	V	26 Insurance		Care Centers Health Systems, Inc.	100.00%	766	766
24	V	30 Depreciation		Care Centers Health Systems, Inc.	100.00%	788	788
25	V	32 Interest		Care Centers Health Systems, Inc.	100.00%		
26	V	33 Real Estate Taxes		Care Centers Health Systems, Inc.	100.00%		
27	V	34 Rent - Building		Care Centers Health Systems, Inc.	100.00%	3,523	3,523
28	V	35 Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	37	37
29	V	01 Dietary	21,606	Care Centers Health Systems, Inc.	100.00%	8,625	(12,981)
30	V	02 Food		Care Centers Health Systems, Inc.	100.00%		
31	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%		
32	V	10 Nursing		Care Centers Health Systems, Inc.	100.00%		
33	V	22 Employee Benefits		Care Centers Health Systems, Inc.	100.00%		
34	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%		
35	V	39 Ancillary	47,208	Care Centers Health Systems, Inc.	100.00%	18,845	(28,363)
36	V	17 Administrative		Care Centers Health Systems, Inc.	100.00%	10,787	10,787
37	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	11,013	11,013
38	V	27 Employee Benefits		Care Centers Health Systems, Inc.	100.00%	4,708	4,708
39	Total		\$ 68,814			\$ 67,640	\$ * (1,174)

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name &amp; ID Number

South Shore Nsg &amp; Rehab Ctr

#

0042119

Report Period Beginning:

01/01/09

Ending:

12/31/09

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sandy Bokor	Relative	Administrative	0.00%	See Attached	1.00	2.00%	Mgmt. Fees	\$ 12,000	17-3	1
2	David Aronin	Shareholder	Administrative	0.83%	See Attached	1.90	3.33%	Alloc. Salary	4,136	17-7	2
3	Mark Steinberg	Relative	Administrative	0.00%	See Attached	2.60	4.73%	Alloc. Salary	7,878	17-7	3
4	Eric Rothner	Relative	Administrative	0.00%	See Attached	1.42	4.73%	Alloc. Salary	15,600	17-3	4
5	Adam Vales	Relative	Clerical	1.88%	See Attached	0.74	1.85%	Alloc. Salary	1,335	22-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 40,949		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

# 0042119

Report Period Beginning:

01/01/09

Ending: 12/31/09

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

# 0042119

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 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	30	\$ 6,770	\$	65,100	\$ 320	1
2	02	Food	Patient Days	30	15,058		65,100	712	2
3	03	Housekeeping	Patient Days	30	14,059		65,100	665	3
4	05	Utilities	Patient Days	30	57,646		65,100	2,727	4
5	06	Maintenance	Patient Days	30	89,465		65,100	4,233	5
6	17	Administrative	Patient Days	30	66,000		65,100	3,122	6
7	19	Professional Fees	Patient Days	30	285,482		65,100	13,506	7
8	20	Dues and Subscriptions	Patient Days	30	56,488		65,100	2,672	8
9	21	Office and Clerical	Patient Days	30	462,313		65,100	21,872	9
10	24	Seminar and Travel	Patient Days	30	1,768		65,100	84	10
11	25	Other Staff Admin. Trans.	Patient Days	30	10,309		65,100	488	11
12	26	Insurance	Patient Days	30	22,668		65,100	1,072	12
13	30	Depreciation	Patient Days	30	115,549		65,100	5,467	13
14	32	Interest	Patient Days	30	1,698,489		65,100	80,354	14
15	33	Real Estate Taxes	Patient Days	30	55,709		65,100	2,636	15
16	34	Rent - Building	Patient Days	30	96,636		65,100	4,572	16
17	35	Rent - Equipment & Auto	Patient Days	30	68,244		65,100	3,229	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,122,653	\$		\$ 147,731	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

# 0042119

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 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	30	219,177	219,177	65,100	10,369	1
2	06	Maintenance (Direct)	Direct	30	82,905	82,905		1,532	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	30	37,501		65,100	1,774	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct	30	8,464	8,464		137	4
5	17	Administrative (Pooled)	Patient Days	30	239,303	239,303	65,100	11,321	5
6	21	Office and Clerical (Pooled)	Patient Days	30	3,599,211	3,599,211	65,100	170,276	6
7	21	Office and Clerical (Direct)	Direct	30	654,174			56,572	7
8	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	30	615,819	615,819	65,100	29,134	8
9	27	Emp. Ben. - Gen. Admin. (Direct)	Direct	30	73,650	73,650	65,100	5,054	9
10	22	Employee Benefits							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				\$ 5,530,203	\$ 4,838,529		\$ 286,169	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

# 0042119

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 Extended Care Clinical 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	03	Housekeeping	Patient Days	30	\$ 1,549	\$	65,100	\$ 73	1
2	05	Utilities	Patient Days	30	3,693		65,100	175	2
3	06	Maintenance	Patient Days	30	477		65,100	23	3
4	19	Professional Fees	Patient Days	30	32,105		65,100	1,519	4
5	20	Dues and Subscriptions	Patient Days	30	213		65,100	10	5
6	21	Office & Clerical	Patient Days	30	27,296		65,100	1,291	6
7	24	Travel and Seminar	Patient Days	30	27,079		65,100	1,281	7
8	26	Insurance	Patient Days	30	1,342		65,100	63	8
9	30	Depreciation	Patient Days	30	25,586		65,100	1,210	9
10	32	Interest	Patient Days	30	309,136		65,100	14,625	10
11	33	Real Estate Taxes	Patient Days	30	6,053		65,100	286	11
12	01	Dietary Salary	Patient Days	30	117,506	117,506	65,100	5,559	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	30	17,040		65,100	806	13
14	10	Nursing Salary	Patient Days	30	799,889	799,889	65,100	37,842	14
15	10a	Rehab Salary	Patient Days	30	45,993	45,993	65,100	2,176	15
16	12	Social Service Salary	Patient Days	30	247,396	247,396	65,100	11,704	16
17	15	Emp. Ben. - Healthcare	Patient Days	30	158,537		65,100	7,500	17
18	17	Administration Salary	Patient Days	30	1,043,375	1,043,375	65,100	49,361	18
19	21	Office Salary	Patient Days	30	206,680	206,680	65,100	9,778	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	30	181,271		65,100	8,576	20
21	10	Nursing Salary	Direct Allocation		494,488	494,488	65,100	96,454	21
22	12	Social Service Salary	Direct Allocation		196,033	196,033		9,273	22
23	15	Emp. Ben. - Healthcare	Direct Allocation		82,560			15,610	23
24									24
25	TOTALS				\$ 4,025,296	\$ 3,151,360		\$ 275,195	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

# 0042119

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation		\$	\$		\$ 627	1
2	3	Housekeeping	Direct Allocation					69,630	2
3	4	Laundry	Direct Allocation					9,629	3
4	6	Repairs & Maintenance	Direct Allocation					545	4
5	10	Nursing	Direct Allocation					146,755	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation					234	7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation					4,296	10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation					72,628	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				\$	\$		\$ 304,344	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

# 0042119

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	Employee Health Insurance	Direct Allocation			\$	\$		\$ 127,204	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				\$	\$		\$ 127,204	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

# 0042119

Report Period Beginning:

01/01/09

Ending: 12/31/09

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	821,185	26	\$ 80,807	\$ 17,925	\$ 1,764	1
2	19	Professional Fees	Direct Billing	821,185	26	4,427	17,925	97	2
3	21	Office and Clerical	Direct Billing	821,185	26	6,852	17,925	150	3
4	25	Auto Expense / Travel	Direct Billing	821,185	26	356	17,925	8	4
5	26	Insurance	Direct Billing	821,185	26	4,573	17,925	100	5
6	30	Depreciation	Direct Billing	821,185	26	218,810	17,925	4,590	6
7	32	Interest	Direct Billing	821,185	26	35,420	17,925	773	7
8	30	Depreciation - Matrix	Patient Days	1,376,056	30	300,546	65,100	14,219	8
9	32	Interest - Matrix	Patient Days	1,376,056	30	54,323	65,100	2,570	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					\$ 706,114	\$	\$ 24,271	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

# 0042119

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Care Centers Health Systems, Inc.  
 Street Address 200 Howard  
 City / State / Zip Code Des Plaines, Illinois 60018  
 Phone Number ( 224) 612-5662  
 Fax Number ( 224) 612-5862

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Gross Billable Income	3,421,940	26	72,652	233,959	4,967	1
2	03	Housekeeping	Gross Billable Income	3,421,940	26		233,959		2
3	05	Heat and Other Utilities	Gross Billable Income	3,421,940	26	5,507	233,959	377	3
4	06	Maintenance	Gross Billable Income	3,421,940	26	4,211	233,959	288	4
5	19	Professional Fees	Gross Billable Income	3,421,940	26	5,880	233,959	402	5
6	20	Dues, Fees, Subscriptions	Gross Billable Income	3,421,940	26	2,401	233,959	164	6
7	21	Clerical and General Office	Gross Billable Income	3,421,940	26	29,869	233,959	2,042	7
8	25	Other Admin. Staff Transport.	Gross Billable Income	3,421,940	26	4,509	233,959	308	8
9	26	Insurance	Gross Billable Income	3,421,940	26	11,210	233,959	766	9
10	30	Depreciation	Gross Billable Income	3,421,940	26	11,528	233,959	788	10
11	32	Interest	Gross Billable Income	3,421,940	26		233,959		11
12	33	Real Estate Taxes	Gross Billable Income	3,421,940	26		233,959		12
13	34	Rent - Building	Gross Billable Income	3,421,940	26	51,522	233,959	3,523	13
14	35	Rent - Equipment	Gross Billable Income	3,421,940	26	547	233,959	37	14
15	01	Dietary	Direct Billable Income	206,522	26	82,445	21,606	8,625	15
16	02	Food	Direct Billable Income	2,784	26	1,111			16
17	03	Housekeeping	Direct Billable Income		26				17
18	10	Nursing	Direct Billable Income	5,466	26	2,182			18
19	22	Employee Benefits	Direct Billable Income	411	26	164			19
20	25	Other Admin. Staff Transport.	Direct Billable Income		26				20
21	39	Ancillary	Direct Billable Income	3,206,757	26	1,280,152	47,208	18,845	21
22	17	Administrative	Gross Billable Income	3,421,940	26	157,769	157,769	10,787	22
23	21	Clerical and General Office	Gross Billable Income	3,421,940	26	161,081	161,081	11,013	23
24	27	Employee Benefits	Gross Billable Income	3,421,940	26	68,860	233,959	4,708	24
25	TOTALS					\$ 1,953,599	\$ 318,850	\$ 67,640	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

# 0042119 Report Period Beginning: 01/01/09 Ending: 12/31/09

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

# 0042119

Report Period Beginning:

01/01/09

Ending: 12/31/09

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

South Shore Nsg & Rehab Ctr

# 0042119

Report Period Beginning:

01/01/09

Ending:

12/31/09

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

	1	2	3	4	5	6	7	8	9	10										
											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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Business Partners LLC		X	Mortgage			\$	\$ 15,618,122		\$	874,007	1								
2												2								
3												3								
4												4								
5	See Supplemental Schedule											5								
<b>Working Capital</b>																				
6	DAIWA		X	Line of Credit				1,262,038			39,501	6								
7	Due to Affiliates										18,762	7								
8	See Supplemental Schedule											8								
9	TOTAL Facility Related					\$	\$	16,880,160		\$	932,270	9								
<b>B. Non-Facility Related*</b>																				
10	Interest Income										(54,500)	10								
11	Interest Income - Bldg. Co.										(263,726)	11								
12	Alloc. Extended Care Consulting		X								80,354	12								
13	See Supplemental Schedule										17,968	13								
14	TOTAL Non-Facility Related					\$	\$			\$	(219,904)	14								
15	TOTALS (line 9+line14)					\$	\$	16,880,160		\$	712,366	15								

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number

South Shore Nsg &amp; Rehab Ctr

# 0042119

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

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

	1	2	3	4	5	6		8	9	10									
						Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES							NO	Original				Balance
	<b>A. Directly Facility Related</b>																		
	<b>Long-Term</b>																		
1							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	<b>TOTAL Long-Term</b>																		
	<b>Working Capital</b>																		
8							\$	\$			\$	8							
9												9							
10												10							
11												11							
12												12							
13												13							
14	<b>TOTAL Working Capital</b>																		
	<b>B. Non-Facility Related*</b>																		
15	Alloc. From Vent Lease						\$	\$			\$	3,343	15						
16	Alloc. Extended Care Clinical		X									14,625	16						
17													17						
18													18						
19													19						
20	<b>TOTAL Non-Facility Related</b>																		
												17,968	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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)







Facility Name & ID Number South Shore Nsg & Rehab Ctr

# 0042119

Report Period Beginning:

01/01/09

Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>	<u>101,000</u>	<u>1994</u>	<u>\$ 352,000</u>	<u>1</u>
2	<u>Alloc. EC Consulting 2201/Clinical 2201</u>			<u>17,363</u>	<u>2</u>
3	<b>TOTALS</b>	<b>101,000</b>		<b>\$ 369,363</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1998	22,697		20	1,135	1,135	12,832	9
10	Various		1999	22,789		20	1,140	1,140	11,713	10
11	Various		2000	41,526		20	2,076	2,076	20,341	11
12	Various		2001	43,128		20	2,158	2,158	18,123	12
13	Various		2002	37,477		20	3,720	3,720	27,649	13
14	Various		2003	38,966		20	4,548	4,548	30,122	14
15	Various		2004	53,775		20	4,800	4,800	35,731	15
16	Various		2005	54,395		20	10,076	10,076	46,415	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12F & 12G)	10,639,989	288,254		313,914	25,660	3,135,865	67
68	Related Party Allocations (Pages 12H & 12I)	68,697	4,692		4,692		28,580	68
69	Financial Statement Depreciation		59,017			(59,017)		69
70	TOTAL (lines 4 thru 69)	\$ 11,023,439	\$ 351,963		\$ 348,259	\$ (3,704)	\$ 3,367,371	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number South Shore Nsg &amp; Rehab Ctr

# 0042119

Report Period Beginning:

01/01/09

Ending:

12/31/09

## 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	<b>Totals from Page 12A, Carried Forward</b>		\$ 11,023,439	\$ 351,963		\$ 348,259	\$ (3,704)	\$ 3,367,371	1
2	Home Office P/R Painting	2006	2,098		20	210	210	734	2
3	Painting-From Hop	2006	5,876		20	588	588	2,008	3
4	Painting-From Hop	2006	8,498		20	850	850	2,833	4
5	Dep On New Fence	2006	2,080		20	208	208	693	5
6	3 Ton A/C- 1/2 Down 1	2006	6,250		20	1,250	1,250	4,479	6
7	Boiler Repair	2006	4,915		20	983	983	3,522	7
8	3 Ton A/C-1/2 Down 2	2006	6,600		20	1,320	1,320	4,510	8
9	Painting - From Hop	2006	5,994		20	599	599	1,948	9
10	Annie Looking 4 Inv	2006	9,341		20	934	934	3,036	10
11	Painting	2006	1,603		20	160	160	508	11
12	Perenials	2006	2,750		20	183	183	642	12
13	Elevator Repairs	2006	2,722		20	136	136	454	13
14	Painting (Transfer Expense From Home Office)	2007	3,690		20			3,690	14
15	Painting (Transfer Expense From Home Office)	2007	7,695		20			7,695	15
16	Replace Laundry Boiler	2007	9,716		20	1,388	1,388	4,048	16
17	Replace Laundry Boiler	2007	9,716		20	1,388	1,388	3,933	17
18	Repair Ahu #1 Coil	2007	19,679		20	3,936	3,936	11,151	18
19	Painting (Transfer Expense From Home Office)	2007	3,426		20			3,426	19
20	Replace Laundry Boiler	2007	9,716		20	1,388	1,388	3,817	20
21	New Telephone System	2007	2,882		20	288	288	793	21
22	Barrier Free Door Closer	2007	4,519		20	452	452	1,205	22
23	Replace Laundry Boiler	2007	9,716		20	1,388	1,388	3,701	23
24	Final Pymt Of 3 - New Oil Coolers	2007	16,854		20	843	843	2,177	24
25	Replace Laundry Boiler	2007	9,716		20	1,388	1,388	3,586	25
26	Tarkett Vct & Install - 1St Fl Nurs Station	2007	20,299		20	2,030	2,030	5,244	26
27	Replace Laundry Boiler	2007	9,716		20	1,388	1,388	3,470	27
28	Tarkett Vcr & Install, 2Nd Fl Nurs Station	2007	17,256		20	1,726	1,726	4,170	28
29	Booster Heater	2007	3,528		20	706	706	1,705	29
30	Major A/C Work	2007	3,493		20	291	291	703	30
31	Fire Alarm Repair	2007	5,149		20	736	736	1,594	31
32	Alarm For Air Unit	2008	3,322		20	332	332	637	32
33	New Laundry Exhaust Fan	2008	5,069		20	507	507	845	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 11,257,323	\$ 351,963		\$ 375,855	\$ 23,892	\$ 3,460,328	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 11,257,323	\$ 351,963		\$ 375,855	\$ 23,892	\$ 3,460,328	1
2	2008	14,625		20	1,463	1,463	2,316	2
3	2008	42,163		20	8,433	8,433	13,352	3
4	2008	35,609		20	3,561	3,561	5,341	4
5	2008	76,500		20	6,375	6,375	7,969	5
6	2008	8,439		20	844	844	1,055	6
7	2009	5,050		20	421	421	421	7
8	2009	26,796		20	2,233	2,233	2,233	8
9	2009	3,480		20	464	464	464	9
10	2009	14,489		20	1,690	1,690	1,690	10
11	2009	44,140		20	2,207	2,207	2,207	11
12	2009	2,788		20	139	139	139	12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 11,531,402	\$ 351,963		\$ 403,685	\$ 51,722	\$ 3,497,515	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 11,531,402	\$ 351,963		\$ 403,685	\$ 51,722	\$ 3,497,515	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,531,402	\$ 351,963		\$ 403,685	\$ 51,722	\$ 3,497,515	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 11,531,402	\$ 351,963		\$ 403,685	\$ 51,722	\$ 3,497,515
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 11,531,402	\$ 351,963		\$ 403,685	\$ 51,722	\$ 3,497,515

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Building Company Information</b>								1
2	<b>Buildings:</b>								2
3	Building	1999	134,000	3,436	35	3,829	393	34,609	3
4	Building	1998	9,683,370	248,292	35	276,668	28,376	2,739,936	4
5	Building	2000	360,000	9,231	35	10,286	1,055	83,748	5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	Land Improvements	1998	462,619	27,295	20	23,131	(4,164)	277,572	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12F & 12G lines 1 thru 33)	\$ 10,639,989	\$ 288,254		\$ 313,914	\$ 25,660	\$ 3,135,865	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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	<b>Related Party Information</b>		\$	\$		\$	\$		1
2	<b>Buildings:</b>								2
3	Allocated from Extended Care Consulting 2201 Main, LLC	2002	21,552	553	39	553		4,030	3
4	Allocated from Extended Care Clinical 2201 Main, LLC	2002	2,374	61	39	61		444	4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	Allocated from Extended Care Consulting, LLC	2007	218	4	20	4		25	9
10	Allocated from Extended Care Consulting, LLC	2009	130	7	20	7		7	10
11	Allocated from Extended Care Consulting 2201 Main, LLC	2002	17,804	1,627	20	1,627		9,778	11
12	Allocated from Extended Care Consulting 2201 Main, LLC	2003	20,981	1,917	20	1,917		11,523	12
13	Allocated from Extended Care Consulting 2201 Main, LLC	2005	1,042	111	20	111		376	13
14	Allocated from Extended Care Consulting 2201 Main, LLC	2009	188	9	20	9		9	14
15									15
16	Allocated from Extended Care Clinical 2201 Main, LLC	2002	1,961	179	20	179		1,077	16
17	Allocated from Extended Care Clinical 2201 Main, LLC	2003	2,311	211	20	211		1,269	17
18	Allocated from Extended Care Clinical 2201 Main, LLC	2005	115	12	20	12		41	18
19	Allocated from Extended Care Clinical 2201 Main, LLC	2009	21	1	20	1		1	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12H & 12I lines 1 thru 33)	\$ 68,697	\$ 4,692		\$ 4,692	\$	\$ 28,580	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 306,136	\$ 37,480	\$ 38,143	\$ 663	10	\$ 255,259	71
72	Current Year Purchases	14,555	39,550	1,937	(37,613)	10	1,937	72
73	Fully Depreciated Assets	2,700,256				10	2,700,256	73
74								74
75	TOTALS	\$ 3,020,947	\$ 77,030	\$ 40,080	\$ (36,950)		\$ 2,957,452	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2002 CHEVY MALIBU	2005	\$ 5,332	\$ 324	\$ 888	\$ 564	5	\$ 4,888	76
77		Allocated from Extended Care Cc	2009	15,213	238	238		5	14,500	77
78		Allocated from Extended Care Cl	2009	3,401	680	680		5	2,003	78
79		Allocated from Care Centers Hea	2009	2,004	401	401		5	2,730	79
80	TOTALS			\$ 25,950	\$ 1,643	\$ 2,207	\$ 564		\$ 24,121	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 14,947,662	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 430,636	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 445,972	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 15,336	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,479,088	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.

**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?  YES  NO

If NO, see instructions.

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:			\$			3
4	Additions						4
5	<u>Alloc. Extended Care Consulting</u>			<u>4,572</u>			5
6	<u>Alloc. Care Centers Health Services, Inc.</u>			<u>3,523</u>			6
7	TOTAL			\$ <u>8,095</u>			7

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: \$ 16,547 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

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

\* 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		Contract	Total
		1 Drop-outs	2 Completed		
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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 294,362	\$		\$ 294,362	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			117,940			117,940	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			305,150			305,150	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 prescrpts				236,250		236,250	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>					39,453	308,415		347,868	13
14	TOTAL			\$		\$ 756,905	\$ 544,665		\$ 1,301,570	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr

# 0042119

Report Period Beginning: 01/01/09

Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 750	\$ 2,994,998	1
2	Cash-Patient Deposits	109,520	109,520	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	879,675	879,675	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	506,947	506,947	6
7	Other Prepaid Expenses	1,503	1,503	7
8	Accounts Receivable (owners or related parties)	1,248,571	1,818,078	8
9	Other(specify): <u>See Attached Schedule</u>	157,844	157,844	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,904,810	\$ 6,468,565	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	2,750	354,750	13
14	Buildings, at Historical Cost		10,177,369	14
15	Leasehold Improvements, at Historical Cost	541,008	1,003,627	15
16	Equipment, at Historical Cost	678,999	3,127,691	16
17	Accumulated Depreciation (book methods)	(744,796)	(6,576,446)	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>		26,347	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 477,961	\$ 8,113,338	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,382,771	\$ 14,581,903	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 1,893,163	\$ 1,893,163	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	79,934	79,934	28
29	Short-Term Notes Payable	1,262,038	1,262,038	29
30	Accrued Salaries Payable	306,766	306,766	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,039	13,039	31
32	Accrued Real Estate Taxes(Sch.IX-B)	327,411	327,411	32
33	Accrued Interest Payable		40,672	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>	467,198	467,198	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 4,349,549	\$ 4,390,221	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		15,618,122	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 15,618,122	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,349,549	\$ 20,008,343	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (966,778)	\$ (5,426,440)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,382,771	\$ 14,581,903	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>6,374,362</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<u>Dividends</u>	(5,080,709)	<b>3</b>
<b>4</b>	<u>Rounding</u>	(6)	<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,293,647</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(2,080,425)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	(180,000)	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (2,260,425)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (966,778)	<b>24</b> *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number South Shore Nsg &amp; Rehab Ctr

# 0042119

Report Period Beginning: 01/01/09

Ending: 12/31/09

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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 11,056,573	1
2	Discounts and Allowances for all Levels	(3,080,550)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,976,023	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,738,435	6
7	Oxygen	22,850	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,761,285	8
<b>C. Other Operating Revenue</b>			
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	241,912	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	29,807	19
20	Radiology and X-Ray	4,830	20
21	Other Medical Services	209,917	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 486,466	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	54,500	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 54,500	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	659	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 659	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 11,278,933	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,176,306	31
32	Health Care	4,411,265	32
33	General Administration	3,690,549	33
<b>B. Capital Expense</b>			
34	Ownership	1,647,963	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,301,875	35
36	Provider Participation Fee	131,400	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 13,359,358	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(2,080,425)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (2,080,425)	43

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

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

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

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

Facility Name & ID Number **South Shore Nsg & Rehab Ctr**

# **0042119**

Report Period Beginning:

**01/01/09**

Ending:

**12/31/09**

**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	1,419	1,570	\$ 67,152	\$ 42.77	1
2	Assistant Director of Nursing	2,346	2,627	87,103	33.16	2
3	Registered Nurses	14,738	16,456	499,630	30.36	3
4	Licensed Practical Nurses	59,651	64,516	1,599,009	24.78	4
5	CNAs & Orderlies	113,230	124,251	1,254,961	10.10	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	13,397	15,033	209,993	13.97	8
9	Activity Director	2,010	2,215	28,680	12.95	9
10	Activity Assistants	12,324	14,156	144,594	10.21	10
11	Social Service Workers	7,820	8,698	145,470	16.72	11
12	Dietician	1,898	1,972	26,136	13.25	12
13	Food Service Supervisor	2,103	2,468	46,423	18.81	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,005	5,708	67,445	11.82	15
16	Dishwashers	25,763	31,421	323,170	10.29	16
17	Maintenance Workers	6,162	7,019	114,614	16.33	17
18	Housekeepers	24,889	28,212	273,625	9.70	18
19	Laundry	13,489	15,792	154,587	9.79	19
20	Administrator	2,051	2,283	100,439	43.99	20
21	Assistant Administrator	1,852	2,111	37,529	17.78	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,372	6,896	83,866	12.16	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,063	2,316	33,216	14.34	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	318,582	355,720	\$ 5,297,642 *	\$ 14.89	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	313	\$ 14,221	01-03	35
36	Medical Director	Monthly	29,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,340	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				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48	<u>See Attached</u>		105,727		48
49	TOTAL (lines 35 - 48)	313	\$ 151,288		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	38	563	10-03	52
53	TOTAL (lines 50 - 52)	38	\$ 563		53

SEE ACCOUNTANTS' COMPILATION REPORT

**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	
Moria Tannen	Administrator		\$ 54,675	Workers' Compensation Insurance	\$ 179,754	IDPH License Fee	\$	
Dora Green	Administrator		45,764	Unemployment Compensation Insurance	89,516	Advertising: Employee Recruitment	13,103	
Roland Carey	Asst. Admin		37,529	FICA Taxes	398,304	Health Care Worker Background Check	5,755	
				Employee Health Insurance	222,023	(Indicate # of checks performed <u>382</u> )		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Fees	4,894	
				City Payroll Tax	7,524	Dues & Subscriptions	25,190	
				Employee Physicals	6,370	Yellow Page Advertising	784	
				Pension Expense	55,947	Alloc. from Extended Care Consulting	2,672	
				Other Employee Benefits	23,041	See Supplemental Schedule	174	
				Holiday Expense	2,413	Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	(784)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 137,968	TOTAL (agree to Schedule V, line 22, col.8)	\$ 984,891	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 51,787	
<b>B. Administrative - Other</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
Description			Amount	Description	Line #	Amount	Description	Amount
Sandy Bokor			\$ 12,000				Out-of-State Travel	\$
Management Fees - Eric Rothner			15,600					
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 27,600				Seminar Expense	8,659
							Alloc. From Extended Care Consulting	84
							Alloc. From Extended Care Clinical	1,281
							Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 604,941	TOTAL		\$	TOTAL	\$ 10,024

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number South Shore Nsg &amp; Rehab Ctr

# 0042119

Report Period Beginning:

01/01/09

Ending:

12/31/09

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. ICLTC: \$18,216 IACHF: \$2,880
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 48,458 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 131,400  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ Np Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.