

Facility Name & ID Number Westshire Nursing & Rehab Ctr

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	3 Private Pay	4 Other	4 Total		
8	SNF	<u>21,781</u>	<u>806</u>	<u>4,423</u>	<u>27,010</u>		8
9	SNF/PED						9
10	ICF	<u>87,438</u>			<u>87,438</u>		10
11	ICF/DD						11
12	SC						12
13	DD 16 OR LESS						13
14	TOTALS	<u>109,219</u>	<u>806</u>	<u>4,423</u>	<u>114,448</u>		14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.65%

D. How many bed-hold days during this year were paid by the Department? 258 (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 9/1/1996

J. Was the facility purchased or leased after January 1, 1978?
YES Date 9/1/1996 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 33 and days of care provided 4,423

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr # 0042325 Report Period Beginning: 01/01/09 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
	A. General Services										
1	Dietary	645,445	50,722	125	696,292		696,292	4,406	700,698		1
2	Food Purchase		482,781		482,781		482,781	486	483,267		2
3	Housekeeping	384,133	88,831		472,964		472,964	(1,998)	470,966		3
4	Laundry	152,207	30,042		182,249		182,249	(225)	182,024		4
5	Heat and Other Utilities			287,925	287,925		287,925	1,743	289,668		5
6	Maintenance	250,947	2,309	198,560	451,816		451,816	(19,899)	431,917		6
7	Other (specify):*							1,885	1,885		7
8	TOTAL General Services	1,432,732	654,685	486,610	2,574,027		2,574,027	(13,602)	2,560,425		8
	B. Health Care and Programs										
9	Medical Director			19,800	19,800		19,800		19,800		9
10	Nursing and Medical Records	3,961,350	147,365	36,425	4,145,140		4,145,140	8,236	4,153,376		10
10a	Therapy	86,649			86,649		86,649	4,614	91,263		10a
11	Activities	182,497	8,929	1,095	192,521		192,521		192,521		11
12	Social Services	439,529	1,264	6,384	447,177		447,177	8,549	455,726		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							7,523	7,523		15
16	TOTAL Health Care and Programs	4,670,025	157,558	63,704	4,891,287		4,891,287	28,922	4,920,209		16
	C. General Administration										
17	Administrative	213,300		175,000	388,300		388,300	48,130	436,430		17
18	Directors Fees										18
19	Professional Services			283,289	283,289	(2,750)	280,539	(161,227)	119,312		19
20	Dues, Fees, Subscriptions & Promotions			37,349	37,349		37,349	(2,375)	34,974		20
21	Clerical & General Office Expenses	162,600	17,525	780,045	960,170		960,170	(523,166)	437,004		21
22	Employee Benefits & Payroll Taxes			1,055,354	1,055,354		1,055,354	(6,317)	1,049,037		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,079	5,079		5,079	997	6,076		24
25	Other Admin. Staff Transportation			9,604	9,604		9,604	407	10,011		25
26	Insurance-Prop.Liab.Malpractice			290,113	290,113		290,113	1,025	291,138		26
27	Other (specify):*							29,236	29,236		27
28	TOTAL General Administration	375,900	17,525	2,635,833	3,029,258	(2,750)	3,026,508	(613,290)	2,413,218		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,478,657	829,768	3,186,147	10,494,572	(2,750)	10,491,822	(597,970)	9,893,852		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			57,040	57,040		57,040	593,975	651,015			30
31	Amortization of Pre-Op. & Org.			8,506	8,506		8,506		8,506			31
32	Interest			56,588	56,588		56,588	517,806	574,394			32
33	Real Estate Taxes			449,342	449,342	2,750	452,092	561,128	1,013,220			33
34	Rent-Facility & Grounds			2,331,000	2,331,000		2,331,000	(1,046,164)	1,284,836			34
35	Rent-Equipment & Vehicles			6,802	6,802		6,802	1,934	8,736			35
36	Other (specify):*							41,850	41,850			36
37	TOTAL Ownership			2,909,278	2,909,278	2,750	2,912,028	670,529	3,582,557			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		162,668	327,288	489,956		489,956	11,072	501,028			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			265,538	265,538		265,538		265,538			42
43	Other (specify):*			3,947	3,947		3,947	(3,947)				43
44	TOTAL Special Cost Centers		162,668	596,773	759,441		759,441	7,125	766,566			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,478,657	992,436	6,692,198	14,163,291		14,163,291	79,684	14,242,975			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	(430)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	308,591	30		9
10	Interest and Other Investment Income	(49,753)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(34)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(578)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,476)	21		18
19	Entertainment				19
20	Contributions	(595)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(76,142)	21		24
25	Fund Raising, Advertising and Promotional	(3,512)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(501)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,133,978)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (959,408)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	1,039,091		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,039,091		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 79,684		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Westshire Nursing & Rehab Ctr

ID# 0042325

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Marketing Expenses	\$ (3,947)	43	1
2	Bank Charges	(970)	21	2
3	Rental Income	(30,744)	06	3
4	Miscellaneous Income	(13,350)	21	4
5	Account Collection Expense	(80)	21	5
6	Prior Period Nursing Expenses	(15,165)	10	6
7	Building Company Audit Fees	(4,167)	19	7
8	Building Company Legal Fees	(8,410)	19	8
9	Building Company Miscellaneous Expenses	(104)	21	9
10	Building Company Bank Fees	(27)	21	10
11	Building Company Architect Fees	(1,046)	19	11
12	Building Company Amortization	(2,101)	31	12
13	Related Party Interest	(140)	32	13
14	Additional R&M	2,771	06	14
15	Annual Report	(250)	20	15
16	Loss on Disposal of Assets	(567,113)	21	16
17	Capitalized R&M	(4,030)	06	17
18	Non-Allowable Legal	(35,145)	19	18
19	Equipment Rental Income	(429)	35	19
20	Equipment Rental Income	(189)	21	20
21	Non-Allowable Real Estate	(449,342)	33	21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,133,978)		49

Westshire Nursing & Rehab Ctr

ID# 0042325

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 Westshire Nursing & Rehab Ctr# 0042325

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			234		4,061					111		4,406	1
2	Food Purchase	(34)		520									486	2
3	Housekeeping			486		54	(2,538)						(1,998)	3
4	Laundry						(225)						(225)	4
5	Heat and Other Utilities	(430)		1,992		128					53		1,743	5
6	Maintenance	(32,003)		3,092	7,574	16	(176)		1,557		41		(19,899)	6
7	Other (specify):*				1,296	589							1,885	7
8	TOTAL General Services	(32,467)		6,324	8,870	4,848	(2,939)		1,557		205		(13,602)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(15,743)				27,642	(3,663)						8,236	10
10a	Therapy					1,589				3,025			4,614	10a
11	Activities													11
12	Social Services					8,549							8,549	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					7,523							7,523	15
16	TOTAL Health Care and Programs	(15,743)				45,303	(3,663)			3,025			28,922	16
	C. General Administration													
17	Administrative			2,281	8,270	36,056					1,523		48,130	17
18	Directors Fees													18
19	Professional Services	(48,768)	13,623	(127,333)		1,109			85		57		(161,227)	19
20	Fees, Subscriptions & Promotions	(4,357)		1,952		7					23		(2,375)	20
21	Clerical & General Office Expenses	(660,952)	131	15,976	124,380	8,085			(12,629)		1,843		(523,166)	21
22	Employee Benefits & Payroll Taxes				(1,026)	(5,193)	(98)						(6,317)	22
23	Inservice Training & Education													23
24	Travel and Seminar			61		936							997	24
25	Other Admin. Staff Transportation			356					7		44		407	25
26	Insurance-Prop.Liab.Malpractice			783		46			88		108		1,025	26
27	Other (specify):*				22,307	6,264					665		29,236	27
28	TOTAL General Administration	(714,077)	13,754	(105,924)	153,931	47,310	(98)		(12,449)		4,263		(613,290)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(762,287)	13,754	(99,600)	162,801	97,461	(6,701)		(10,892)	3,025	4,468		(597,970)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Westshire Nursing & Rehab Ctr# 0042325

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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	308,591	264,257	3,993		884			16,139		111		593,975	30
31	Amortization of Pre-Op. & Org.	(2,101)	2,101											31
32	Interest	(49,893)	495,762	58,695		10,683			2,559				517,806	32
33	Real Estate Taxes	(449,342)	1,008,336	1,925		209							561,128	33
34	Rent-Facility & Grounds		(1,050,000)	3,339							497		(1,046,164)	34
35	Rent-Equipment & Vehicles	(429)		2,358							5		1,934	35
36	Other (specify):*		41,850										41,850	36
37	TOTAL Ownership	(193,174)	762,306	70,310		11,776			18,698		613		670,529	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(3,315)		(15,820)	33,115	(2,908)		11,072	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(3,947)											(3,947)	43
44	TOTAL Special Cost Centers	(3,947)					(3,315)		(15,820)	33,115	(2,908)		7,125	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(959,408)	776,060	(29,290)	162,801	109,237	(10,016)		(8,014)	36,140	2,173		79,684	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 1,050,000	Westshire Health Care Properties LLC	100.00%	\$	\$ (1,050,000)	1
2	V	32 Interest Income	619	Westshire Health Care Properties LLC	100.00%		(619)	2
3	V	19 Audit Fees		Westshire Health Care Properties LLC	100.00%	4,167	4,167	3
4	V	19 Legal Expense		Westshire Health Care Properties LLC	100.00%	8,410	8,410	4
5	V	21 Miscellaneous Expenses		Westshire Health Care Properties LLC	100.00%	104	104	5
6	V	21 Bank Charges		Westshire Health Care Properties LLC	100.00%	27	27	6
7	V	19 Architect Fees		Westshire Health Care Properties LLC	100.00%	1,046	1,046	7
8	V	30 Depreciation		Westshire Health Care Properties LLC	100.00%	264,257	264,257	8
9	V	31 Amortization		Westshire Health Care Properties LLC	100.00%	2,101	2,101	9
10	V	33 Real Estate Tax Expense		Westshire Health Care Properties LLC	100.00%	1,008,336	1,008,336	10
11	V	32 Interest Expense		Westshire Health Care Properties LLC	100.00%	496,381	496,381	11
12	V	36 MIP		Westshire Health Care Properties LLC	100.00%	41,850	41,850	12
13	V							13
14	Total		\$ 1,050,619			\$ 1,826,679	\$ * 776,060	14

* 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%	7,574	\$	7,574	15
16	V	06 Maintenance (Direct)		Extended Care Consulting, LLC	100.00%				16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,296		1,296	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%				18
19	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	8,270		8,270	19
20	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	124,380		124,380	20
21	V	21 Office and Clerical (Direct)	10,695	Extended Care Consulting, LLC	100.00%	10,695			21
22	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	21,281		21,281	22
23	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	1,026		1,026	23
24	V	22 Employee Benefits	1,026	Extended Care Consulting, LLC	100.00%			(1,026)	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		\$ 11,721			\$ 174,522	\$ *	162,801	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	01 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 234	\$	234	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	520		520	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	486		486	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	1,992		1,992	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	3,092		3,092	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	2,281		2,281	20
21	V	19 Professional Fees	137,199	Extended Care Consulting, LLC	100.00%	9,866		(127,333)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,952		1,952	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	15,976		15,976	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	61		61	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	356		356	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	783		783	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	3,993		3,993	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	58,695		58,695	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,925		1,925	29
30	V	34 Rent - Building		Extended Care Consulting, LLC	100.00%	3,339		3,339	30
31	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	2,358		2,358	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 137,199			\$ 107,909	\$ *	(29,290)	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%	\$ 54	\$	54	15
16	V	05 Utilities		Extended Care Clinical, LLC	100.00%	128		128	16
17	V	06 Maintenance		Extended Care Clinical, LLC	100.00%	16		16	17
18	V	19 Professional Fees		Extended Care Clinical, LLC	100.00%	1,109		1,109	18
19	V	20 Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	7		7	19
20	V	21 Office & Clerical		Extended Care Clinical, LLC	100.00%	943		943	20
21	V	24 Travel and Seminar		Extended Care Clinical, LLC	100.00%	936		936	21
22	V	26 Insurance		Extended Care Clinical, LLC	100.00%	46		46	22
23	V	30 Depreciation		Extended Care Clinical, LLC	100.00%	884		884	23
24	V	32 Interest		Extended Care Clinical, LLC	100.00%	10,683		10,683	24
25	V	33 Real Estate Taxes		Extended Care Clinical, LLC	100.00%	209		209	25
26	V	01 Dietary Salary		Extended Care Clinical, LLC	100.00%	4,061		4,061	26
27	V	07 Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	589		589	27
28	V	10 Nursing Salary	19,800	Extended Care Clinical, LLC	100.00%	47,442		27,642	28
29	V	10a Rehab Salary		Extended Care Clinical, LLC	100.00%	1,589		1,589	29
30	V	12 Social Service Salary	600	Extended Care Clinical, LLC	100.00%	9,149		8,549	30
31	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	7,523		7,523	31
32	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	36,056		36,056	32
33	V	21 Office Salary		Extended Care Clinical, LLC	100.00%	7,142		7,142	33
34	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	6,264		6,264	34
35	V	22 Employee Benefits	5,193	Extended Care Clinical, LLC	100.00%			(5,193)	35
36	V								36
37	V								37
38	V								38
39	Total		\$ 25,593			\$ 134,830	\$ *	109,237	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	3 Housekeeping	27,636	Xcel Supply, LLC	100.00%	25,098	(2,538)	16
17	V	4 Laundry	2,453	Xcel Supply, LLC	100.00%	2,228	(225)	17
18	V	6 Repairs & Maintenance	1,918	Xcel Supply, LLC	100.00%	1,742	(176)	18
19	V	10 Nursing	39,887	Xcel Supply, LLC	100.00%	36,225	(3,663)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service		Xcel Supply, LLC	100.00%			21
22	V	20 Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits	1,073	Xcel Supply, LLC	100.00%	974	(98)	24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary	36,104	Xcel Supply, LLC	100.00%	32,789	(3,315)	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		\$ 109,071			\$ 99,055	\$ * (10,016)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 115,776	\$ 115,776	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	115,776	CCS Employee Benefits Group	100.00%		(115,776)	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		\$ 115,776			\$ 115,776	\$ *	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%	\$ 1,557	\$ 1,557
16	V	19 Professional Fees		Vent Lease, LLC.	100.00%	85	85
17	V	21 Office and Clerical		Vent Lease, LLC.	100.00%	132	132
18	V	25 Auto Expense / Travel		Vent Lease, LLC.	100.00%	7	7
19	V	26 Insurance		Vent Lease, LLC.	100.00%	88	88
20	V	30 Depreciation		Vent Lease, LLC.	100.00%	5,753	5,753
21	V	32 Interest		Vent Lease, LLC.	100.00%	682	682
22	V	30 Depreciation - Matrix		Vent Lease, LLC.	100.00%	10,386	10,386
23	V	32 Interest - Matrix		Vent Lease, LLC.	100.00%	1,877	1,877
24	V	21 Office and Clerical	12,761	Vent Lease, LLC.	100.00%		(12,761)
25	V	39 Ancillary	15,820	Vent Lease, LLC.	100.00%		(15,820)
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		\$ 28,581			\$ 20,567	\$ * (8,014)

* 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	39 THERAPY	\$ 85,092	TRICARE REHAB		\$ 118,207	\$ 33,115	15
16	V	10A REHAB				3,025	3,025	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 85,092			\$ 121,232	\$ * 36,140	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	01 Dietary	\$	Care Centers Health Systems, Inc.	100.00%	\$ 701	\$	701	15
16	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%				16
17	V	05 Heat and Other Utilities		Care Centers Health Systems, Inc.	100.00%	53		53	17
18	V	06 Maintenance		Care Centers Health Systems, Inc.	100.00%	41		41	18
19	V	19 Professional Fees		Care Centers Health Systems, Inc.	100.00%	57		57	19
20	V	20 Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	23		23	20
21	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	288		288	21
22	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	44		44	22
23	V	26 Insurance		Care Centers Health Systems, Inc.	100.00%	108		108	23
24	V	30 Depreciation		Care Centers Health Systems, Inc.	100.00%	111		111	24
25	V	32 Interest		Care Centers Health Systems, Inc.	100.00%				25
26	V	33 Real Estate Taxes		Care Centers Health Systems, Inc.	100.00%				26
27	V	34 Rent - Building		Care Centers Health Systems, Inc.	100.00%	497		497	27
28	V	35 Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	5		5	28
29	V	01 Dietary	982	Care Centers Health Systems, Inc.	100.00%	392		(590)	29
30	V	02 Food		Care Centers Health Systems, Inc.	100.00%				30
31	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%				31
32	V	10 Nursing		Care Centers Health Systems, Inc.	100.00%				32
33	V	22 Employee Benefits		Care Centers Health Systems, Inc.	100.00%				33
34	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%				34
35	V	39 Ancillary	4,841	Care Centers Health Systems, Inc.	100.00%	1,933		(2,908)	35
36	V	17 Administrative		Care Centers Health Systems, Inc.	100.00%	1,523		1,523	36
37	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	1,555		1,555	37
38	V	27 Employee Benefits		Care Centers Health Systems, Inc.	100.00%	665		665	38
39	Total		\$ 5,823			\$ 7,996	\$ *	2,173	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	Total		\$			\$	\$ *	39

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

Facility Name & ID Number

Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning:

01/01/09

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	Eric Rothner	Owner	Administrative	9.60%	See Attached	1.04	3.46%		\$		1
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	1.90	3.46%	AI Sal/AI Fee	5,755	17-7	2
3	Adam Vales	Owner	Clerical	2.48%	See Attached	0.67	1.68%	Alloc. Salary	1,215	22-7	3
4	Steve Miretzky	Owner	Admin. / Clerical	.41%	See Attached	1.38	3.45%	Alloc. Salary	2,813	21-7	4
5	David Aronin	Owner	Administrative	.82%	See Attached	1.39	2.44%	Alloc. Salary	3,021	17-7	5
6	Shimon Webster	Owner	Administrative	32.47%	See Attached	35.00	58.33%	Sal/Mgmt Fee	166,555	17-1; 17-3	6
7	Yeruchom Levovitz	Owner	Administrative	30.31%	See Attached	35.00	58.33%	Sal/Mgmt Fee	166,555	17-1; 17-3	7
8	Moshe Levovitz	Relative	Administrative	0.00%	None	40.00	100.00%	Salary	17,572	17-1	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 363,486		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____)

Fax Number (_____)

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									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning:

01/01/09

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	\$	47,553	\$ 234	1
2	02	Food	Patient Days	30	15,058		47,553	520	2
3	03	Housekeeping	Patient Days	30	14,059		47,553	486	3
4	05	Utilities	Patient Days	30	57,646		47,553	1,992	4
5	06	Maintenance	Patient Days	30	89,465		47,553	3,092	5
6	17	Administrative	Patient Days	30	66,000		47,553	2,281	6
7	19	Professional Fees	Patient Days	30	285,482		47,553	9,866	7
8	20	Dues and Subscriptions	Patient Days	30	56,488		47,553	1,952	8
9	21	Office and Clerical	Patient Days	30	462,313		47,553	15,976	9
10	24	Seminar and Travel	Patient Days	30	1,768		47,553	61	10
11	25	Other Staff Admin. Trans.	Patient Days	30	10,309		47,553	356	11
12	26	Insurance	Patient Days	30	22,668		47,553	783	12
13	30	Depreciation	Patient Days	30	115,549		47,553	3,993	13
14	32	Interest	Patient Days	30	1,698,489		47,553	58,695	14
15	33	Real Estate Taxes	Patient Days	30	55,709		47,553	1,925	15
16	34	Rent - Building	Patient Days	30	96,636		47,553	3,339	16
17	35	Rent - Equipment & Auto	Patient Days	30	68,244		47,553	2,358	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,122,653	\$		\$ 107,909	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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	47,553	7,574	1
2	06	Maintenance (Direct)	Direct	30	82,905	82,905			2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	30	37,501		47,553	1,296	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct	30	8,464	8,464			4
5	17	Administrative (Pooled)	Patient Days	30	239,303	239,303	47,553	8,270	5
6	21	Office and Clerical (Pooled)	Patient Days	30	3,599,211	3,599,211	47,553	124,380	6
7	21	Office and Clerical (Direct)	Direct	30	654,174			10,695	7
8	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	30	615,819	615,819	47,553	21,281	8
9	27	Emp. Ben. - Gen. Admin. (Direct)	Direct	30	73,650	73,650	47,553	1,026	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		\$ 174,522	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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	1,376,056	30	\$ 1,549	\$ 47,553	\$ 54	1
2	05	Utilities	Patient Days	1,376,056	30	3,693	47,553	128	2
3	06	Maintenance	Patient Days	1,376,056	30	477	47,553	16	3
4	19	Professional Fees	Patient Days	1,376,056	30	32,105	47,553	1,109	4
5	20	Dues and Subscriptions	Patient Days	1,376,056	30	213	47,553	7	5
6	21	Office & Clerical	Patient Days	1,376,056	30	27,296	47,553	943	6
7	24	Travel and Seminar	Patient Days	1,376,056	30	27,079	47,553	936	7
8	26	Insurance	Patient Days	1,376,056	30	1,342	47,553	46	8
9	30	Depreciation	Patient Days	1,376,056	30	25,586	47,553	884	9
10	32	Interest	Patient Days	1,376,056	30	309,136	47,553	10,683	10
11	33	Real Estate Taxes	Patient Days	1,376,056	30	6,053	47,553	209	11
12	01	Dietary Salary	Patient Days	1,376,056	30	117,506	47,553	4,061	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	1,376,056	30	17,040	47,553	589	13
14	10	Nursing Salary	Patient Days	1,376,056	30	799,889	47,553	27,642	14
15	10a	Rehab Salary	Patient Days	1,376,056	30	45,993	47,553	1,589	15
16	12	Social Service Salary	Patient Days	1,376,056	30	247,396	47,553	8,549	16
17	15	Emp. Ben. - Healthcare	Patient Days	1,376,056	30	158,537	47,553	5,479	17
18	17	Administration Salary	Patient Days	1,376,056	30	1,043,375	47,553	36,056	18
19	21	Office Salary	Patient Days	1,376,056	30	206,680	47,553	7,142	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	1,376,056	30	181,271	47,553	6,264	20
21	10	Nursing Salary	Direct Allocation			494,488	47,553	19,800	21
22	12	Social Service Salary	Direct Allocation			196,033	47,553	600	22
23	15	Emp. Ben. - Healthcare	Direct Allocation			82,560		2,044	23
24									24
25	TOTALS					\$ 4,025,296	\$ 3,151,360	\$ 134,830	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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		\$	\$		\$	1
2	3	Housekeeping	Direct Allocation					25,098	2
3	4	Laundry	Direct Allocation					2,228	3
4	6	Repairs & Maintenance	Direct Allocation					1,742	4
5	10	Nursing	Direct Allocation					36,225	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation					974	10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation					32,789	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				\$	\$		\$	99,055

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 115,776	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				\$	\$		\$ 115,776	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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	06	Repairs	Direct Billing	821,185	26	\$ 80,807	\$ 15,820	\$ 1,557	1
2	19	Professional Fees	Direct Billing	821,185	26	4,427	15,820	85	2
3	21	Office and Clerical	Direct Billing	821,185	26	6,852	15,820	132	3
4	25	Auto Expense / Travel	Direct Billing	821,185	26	356	15,820	7	4
5	26	Insurance	Direct Billing	821,185	26	4,573	15,820	88	5
6	30	Depreciation	Direct Billing	821,185	26	218,810	15,820	5,753	6
7	32	Interest	Direct Billing	821,185	26	35,420	15,820	682	7
8	30	Depreciation - Matrix	Patient Days	1,376,056	30	300,546	47,553	10,386	8
9	32	Interest - Matrix	Patient Days	1,376,056	30	54,323	47,553	1,877	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	\$	\$ 20,567	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

TriCare Rehab

Street Address

150 Fencil Lane

City / State / Zip Code

Hillside, IL 60162

Phone Number

(773) 449-9400

Fax Number

(773) 449-9700

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	39	THERAPY	DIRECT ALLOCATION		\$	\$		\$ 118,207	1
2	10A	REHAB	DIRECT ALLOCATION					3,025	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				\$	\$		\$ 121,232	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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

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

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	01	Dietary	Gross Billable Income	3,421,940	26	72,652	33,037	701	1	
2	03	Housekeeping	Gross Billable Income	3,421,940	26		33,037		2	
3	05	Heat and Other Utilities	Gross Billable Income	3,421,940	26	5,507	33,037	53	3	
4	06	Maintenance	Gross Billable Income	3,421,940	26	4,211	33,037	41	4	
5	19	Professional Fees	Gross Billable Income	3,421,940	26	5,880	33,037	57	5	
6	20	Dues, Fees, Subscriptions	Gross Billable Income	3,421,940	26	2,401	33,037	23	6	
7	21	Clerical and General Office	Gross Billable Income	3,421,940	26	29,869	33,037	288	7	
8	25	Other Admin. Staff Transport.	Gross Billable Income	3,421,940	26	4,509	33,037	44	8	
9	26	Insurance	Gross Billable Income	3,421,940	26	11,210	33,037	108	9	
10	30	Depreciation	Gross Billable Income	3,421,940	26	11,528	33,037	111	10	
11	32	Interest	Gross Billable Income	3,421,940	26		33,037		11	
12	33	Real Estate Taxes	Gross Billable Income	3,421,940	26		33,037		12	
13	34	Rent - Building	Gross Billable Income	3,421,940	26	51,522	33,037	497	13	
14	35	Rent - Equipment	Gross Billable Income	3,421,940	26	547	33,037	5	14	
15	01	Dietary	Direct Billable Income	206,522	26	82,445	982	392	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	4,841	1,933	21	
22	17	Administrative	Gross Billable Income	3,421,940	26	157,769	157,769	33,037	1,523	22
23	21	Clerical and General Office	Gross Billable Income	3,421,940	26	161,081	161,081	33,037	1,555	23
24	27	Employee Benefits	Gross Billable Income	3,421,940	26	68,860	33,037	665	24	
25	TOTALS					\$ 1,953,599	\$ 318,850	\$ 7,996	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Westshire Nursing & Rehab Ctr

0042325

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			
	A. Directly Facility Related																				
	Long-Term																				
1	HUD		X	Mortgage			\$	\$ 19,990,233			\$ 496,381	1									
2												2									
3												3									
4												4									
5	See Supplemental Schedule											5									
	Working Capital																				
6	Bank Leumi		X	Note Payable							34,256	6									
7	MB Financial		X	Line of Credit				900,000			15,713	7									
8	See Supplemental Schedule										140	8									
9	TOTAL Facility Related						\$	\$ 20,890,233			\$ 546,490	9									
	B. Non-Facility Related*																				
10	Interest Income		X								(49,753)	10									
11	Interest Income- Bldg Co.		X								(619)	11									
12	Allocated From EC Consult		X								58,695	12									
13	See Supplemental Schedule										19,581	13									
14	TOTAL Non-Facility Related						\$	\$			\$ 27,904	14									
15	TOTALS (line 9+line14)						\$	\$ 20,890,233			\$ 574,394	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 41,850 Line # 36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning:

01/01/09

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
	A. Directly Facility Related																		
	Long-Term																		
1							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	TOTAL Long-Term																		
	Working Capital																		
8	Vent Lease	X					\$	\$			\$	140	8						
9												9							
10												10							
11												11							
12												12							
13												13							
14	TOTAL Working Capital																		
	B. Non-Facility Related*																		
15	Related Party Interest	X					\$	\$			\$	(140)	15						
16	Auto Financing		X									6,479	16						
17	Allocated From EC Clinical		X									10,683	17						
18	Allocated From Vent Lease		X									2,559	18						
19												19							
20	TOTAL Non-Facility Related																		

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325 Report Period Beginning:

01/01/09 Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 124,020 B. General Construction Type: Exterior Masonry Frame _____ Number of Stories _____

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

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

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

None

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

1. Total Amount Incurred: 42,523 2. Number of Years Over Which it is Being Amortized: 25/2
3. Current Period Amortization: 8,506 4. Dates Incurred: 2009

Nature of Costs: Organizational Expenses/Loan Fees
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>23,531</u>	<u>1996</u>	<u>\$ 120,000</u>	<u>1</u>
2	<u>Allocated From EC Consulting 2201 Main/EC Clinical 2201 Main</u>			<u>12,683</u>	<u>2</u>
3	TOTALS	23,531		\$ 132,683	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Various		1996	3,490		20	89	89	1,174
10	Various		1997	58,633		20	1,503	1,503	18,856
11	Various		1998	73,844		20	1,893	1,893	21,854
12	Various		1999	19,521		20	501	501	5,277
13	Various		2000	37,266		20	1,355	1,355	12,929
14	Various		2001	53,553		20	1,947	1,947	16,633
15	Various		2002	40,664		20	1,043	1,043	7,863
16	Various		2003	38,215		20	980	980	6,410
17	Various		2005	77,143		20	7,051	7,051	30,890
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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)	21,272,103	264,257		584,518	320,261	6,512,010	67
68	Related Party Allocations (Pages 12H & 12I)	50,180	3,429		3,429		20,877	68
69	Financial Statement Depreciation		31,271			(31,271)		69
70	TOTAL (lines 4 thru 69)	\$ 21,724,612	\$ 298,957		\$ 604,309	\$ 305,352	\$ 6,654,773	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning:

01/01/09

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	Totals from Page 12A, Carried Forward		\$ 21,724,612	\$ 298,957		\$ 604,309	\$ 305,352	\$ 6,654,773	1
2	Bath And Shower Room Remodeling	2006	15,000		20	1,001	1,001	3,501	2
3	Bright Electric	2006	5,518		20	368	368	1,288	3
4	Hvac For Elevator	2006	9,277		20	619	619	2,165	4
5	Bathroom Renovation	2006	27,377		20	1,826	1,826	6,390	5
6	Circuit Breaker	2006	3,500		20	233	233	817	6
7	S. Electronic	2006	1,564		20	104	104	365	7
8	Duct System	2007	33,500		20	1,675	1,675	4,606	8
9	Painting (Transfer Expense From Home Office)	2007	5,560		20			5,560	9
10	Dairy Cooling System	2007	10,125		20	506	506	1,223	10
11	New Water Main Pipes	2007	113,300		20	5,665	5,665	13,690	11
12	Ac Unit	2007	12,022		20	1,002	1,002	2,338	12
13	Install Cable & Electrical	2007	2,682		20	134	134	346	13
14	Voice Evacuation System	2008	26,938		20	3,700	3,700	8,017	14
15	Fix Heating Problem	2008	2,580		20	129	129	258	15
16	Replace Compressor	2008	11,398		20	760	760	950	16
17	Wiring For Matrix	2008	8,527		20	426	426	568	17
18	Elevator Improvement - Relay	2009	3,291		20	61	61	61	18
19	Elevator Improvement	2009	3,714		20	69	69	69	19
20	Engineering And Electrical	2009	14,500		20	725	725	725	20
21	Hot Water Repairs	2009	5,110		20	234	234	234	21
22	Heat On 1St Floor	2009	5,440		20	249	249	249	22
23	Sewer Line Repair	2009	2,600		20	87	87	87	23
24	Air Conditioning Repairs	2009	4,030		20	202	202	202	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)		\$ 22,052,165	\$ 298,957		\$ 624,083	\$ 325,126	\$ 6,708,482	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning:

01/01/09

Ending:

12/31/09

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		\$ 22,052,165	\$ 298,957		\$ 624,083	\$ 325,126	\$ 6,708,482
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)	\$ 22,052,165	\$ 298,957		\$ 624,083	\$ 325,126	\$ 6,708,482

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		\$ 22,052,165	\$ 298,957		\$ 624,083	\$ 325,126	\$ 6,708,482
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)	\$ 22,052,165	\$ 298,957		\$ 624,083	\$ 325,126	\$ 6,708,482

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning:

01/01/09

Ending:

12/31/09

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		\$ 22,052,165	\$ 298,957		\$ 624,083	\$ 325,126	\$ 6,708,482
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)	\$ 22,052,165	\$ 298,957		\$ 624,083	\$ 325,126	\$ 6,708,482

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning:

01/01/09

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	Building Company Information								1
2	Buildings:								2
3	485 Beds	1974	19,609,780		39	502,815	502,815	6,243,285	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	2 Hot Water Heaters	2004	22,404		20			6,441	9
10	Vertical Pumps	2004	5,860		20			1,673	10
11	New Conduit	2004	3,160		20	158	158	902	11
12	Plumbing	2004	15,337		20	767	767	4,377	12
13	Compressor	2004	11,023		20	551	551	3,054	13
14	Elevator Door	2004	38,820		20	1,941	1,941	10,271	14
15	Remodel Patient Room	2005	10,000		20	500	500	4,250	15
16	Overbed Lights	2005	7,157		20	358	358	2,982	16
17	Passenger Elevator 3	2006	21,900		20	1,095	1,095	4,836	17
18	Modernize 3 Elevators	2006	197,100		20	9,855	9,855	41,884	18
19	5th Floor Rehab (Nurses Station)	2006	15,480		20	774	774	6,063	19
20	5th Floor Rehab (Drawings)	2006	6,605		20	330	330	2,587	20
21	Remove & Replace Doors	2006	5,836		20	292	292	2,237	21
22	5th Floor Rehab (Remodel of Bathrooms)	2006	76,000		20	3,800	3,800	27,233	22
23	5th Floor Rehab (Drawings)	2006	16,763		20	838	838	6,007	23
24	Elevator Wiring, HVAC Wiring, Elevator Recall System	2006	56,300		20	2,815	2,815	22,520	24
25	Tiling	2007	12,500		20	625	625	2,361	25
26	Fire Panel	2008	67,587		20	3,379	3,379	26,549	26
27	Repair Shower Room	2007	11,200		20	560	560	2,987	27
28	Compressor	2007	6,250		20	313	313	1,510	28
29	Accessories for AC Unit	2007	8,092		20	405	405	1,573	29
30	Patio Fence	2007	4,800		20	240	240	1,120	30
31	Replace Doors and Build Frames	2007	7,100		20	355	355	1,598	31
32	Doors	2007	3,442		20	172	172	373	32
33	Fire Panel	2008	5,947		20	297	297	594	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	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company Information Continued		\$	\$		\$	\$	\$	1
2									2
3									3
4	New Furnace	2007	5,170		20	259	259	1,041	4
5	Fire Alarm System Install	2008	86,574		20	4,329	4,329	26,797	5
6	Electrical Wiring 8th Floor	2008	5,000		20	250	250	958	6
7	Electrical Wiring 3th Floor	2008	6,000		20	300	300	1,150	7
8	Replace Compressor - Walk in Freezer	2008	3,500		20	175	175	496	8
9	Replaced Condensor Fans	2008	2,996		20	150	150	399	9
10	HVAC Repairs	2008	31,086		20	1,554	1,554	5,181	10
11	Windows	2009	238,450		20	11,923	11,923	11,923	11
12	Electical Wiring - Eletrical Outlets	2009	33,000		20	1,650	1,650	1,925	12
13	Flooring, Drop Ceiling, Lighting, Entranceway Door	2009	100,850		20	5,043	5,043	5,043	13
14	Visitor Bathroom Tiling Toliets Sink	2009	30,000		20	1,500	1,500	1,500	14
15	Lawn Sprinkler	2009	7,975		20	399	399	266	15
16	Roof	2009	4,275		20	214	214	249	16
17	Landscape	2009	17,000		20	850	850	850	17
18	Upgrade Of HVAC Equipment, Install Sensors	2009	247,379		20	12,369	12,369	10,307	18
19	1st Floor - Installed Membrance, Tile Drain System	2009	8,650		20	433	433	505	19
20	Cable Outlets	2009	26,640		20	1,332	1,332	1,332	20
21	Painting Wallpaper Carpet Drop Ceiling	2009	79,668		20	3,983	3,983	3,983	21
22	Offices-Pegasis Custom Built In Furniture	2009	63,000		20	3,150	3,150	3,150	22
23	5th Floor Rehab (Overbed Lights)	2006	6,940		20	347	347	1,388	23
24	Butterfly Valves for Chiller	2006	2,739		20	137	137	548	24
25	5th Floor Rehab (Cubicle Curtains)	2006	8,787		20	439	439	1,756	25
26	6th Floor Rehab (Cubicle Curtains)	2006	9,981		20	499	499	1,996	26
27									27
28									28
29	Total Depreciation- Westshire HC Properties			264,257			(264,257)		29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		\$ 21,272,103	\$ 264,257		\$ 584,518	\$ 320,261	\$ 6,512,010	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	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated From Extended Care Consulting 2201 Main	2002	15,743	404	39	404		2,943	3
4	Allocated From Extended Care Clinical 2201 Main	2002	1,734	44	39	44		324	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From Extended Care Consulting	2007	159	3	20	3		19	9
10	Allocated From Extended Care Consulting	2009	95	5	20	5		5	10
11									11
12	Allocated From Extended Care Consulting 2201 Main	2002	13,005	1,189	20	1,189		7,142	12
13	Allocated From Extended Care Consulting 2201 Main	2003	15,326	1,401	20	1,401		8,417	13
14	Allocated From Extended Care Consulting 2201 Main	2005	761	81	20	81		275	14
15	Allocated From Extended Care Consulting 2201 Main	2009	137	7	20	7		7	15
16									16
17	Allocated From Extended Care Clinical 2201 Main	2002	1,433	131	20	131		787	17
18	Allocated From Extended Care Clinical 2201 Main	2003	1,688	154	20	154		927	18
19	Allocated From Extended Care Clinical 2201 Main	2005	84	9	20	9		30	19
20	Allocated From Extended Care Clinical 2201 Main	2009	15	1	20	1		1	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.

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

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	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)		\$ 50,180	\$ 3,429		\$ 3,429	\$ 20,877	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	\$ 185,506	\$ 22,966	\$ 23,377	\$ 411	10	\$ 138,353	71
72	Current Year Purchases	30,598	19,772	2,826	(16,946)	10	2,826	72
73	Fully Depreciated Assets	1,133,347				10	1,133,347	73
74								74
75	TOTALS	\$ 1,349,451	\$ 42,738	\$ 26,203	\$ (16,535)		\$ 1,274,526	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		Alloc. From EC Consulting	2009	\$ 11,112	\$ 174	\$ 174	\$	5	\$ 10,592	76
77		Alloc. From EC Clinical	2009	2,484	497	497		5	1,463	77
78		Alloc. From EC Health Systems	2009	283	57	57		5	85	78
79										79
80	TOTALS			\$ 13,879	\$ 728	\$ 728	\$		\$ 12,140	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)	\$ 23,548,178	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 342,423	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 651,014	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 308,591	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,995,148	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Westshire Health Care Property LLC

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

If NO, see instructions. YES NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>485</u>		\$ <u>1,281,000</u>			3
4	Additions						4
5	<u>Allocated From Extended Care Consulting</u>			<u>3,339</u>			5
6	<u>Allocated From Extended Care Health Systems</u>			<u>497</u>			6
7	TOTAL	<u>485</u>		\$ <u>1,284,836</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: \$ 8,736 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. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

* 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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	Cost			Units	Cost								
1	Licensed Occupational Therapist	39 - 03	hrs	\$				\$ 71,570	\$				\$ 71,570			1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					132						132		2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39 - 03	hrs					193,051						193,051		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							156,008				156,008		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>							62,535		6,660				69,195		13
14	TOTAL			\$				\$ 327,288	\$	162,668			\$	489,956		14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr# 0042325Report Period Beginning: 01/01/09Ending: 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*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 73,504	\$ 462,227	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,272,885	2,272,885	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	159,006	159,006	6
7	Other Prepaid Expenses		25,044	7
8	Accounts Receivable (owners or related parties)		67,035	8
9	Other(specify): <u>See Attached Schedule</u>	94,054	883,495	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,599,449	\$ 3,869,692	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		120,000	13
14	Buildings, at Historical Cost		19,609,781	14
15	Leasehold Improvements, at Historical Cost	8,340	1,466,949	15
16	Equipment, at Historical Cost	21,502	269,098	16
17	Accumulated Depreciation (book methods)	(25,311)	(7,096,690)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	27,663	27,663	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(1,076)	(1,076)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	507,430	664,615	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 538,548	\$ 15,060,340	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,137,997	\$ 18,930,032	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 732,075	\$ 728,782	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	659,590	659,590	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		921,700	32
33	Accrued Interest Payable		98,785	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	205,620	241,607	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,597,285	\$ 2,650,464	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	900,000	900,000	39
40	Mortgage Payable		19,990,233	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 900,000	\$ 20,890,233	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,497,285	\$ 23,540,697	46
47	TOTAL EQUITY(page 18, line 24)	\$ 640,712	\$ (4,610,665)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,137,997	\$ 18,930,032	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,879,433)	1
2	Restatements (describe):		2
3	Westshire Equity Restructure	3,761,425	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 881,992	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(241,280)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (241,280)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 640,712	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning: 01/01/09

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 13,834,915	1
2	Discounts and Allowances for all Levels	(615,498)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,219,417	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	283,598	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 283,598	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	77,333	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	18,065	19
20	Radiology and X-Ray	2,250	20
21	Other Medical Services	31,040	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 128,688	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	49,753	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 49,753	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	240,555	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 240,555	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,922,011	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,574,027	31
32	Health Care	4,891,287	32
33	General Administration	3,029,258	33
B. Capital Expense			
34	Ownership	2,909,278	34
C. Ancillary Expense			
35	Special Cost Centers	493,903	35
36	Provider Participation Fee	265,538	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,163,291	40
41	Income before Income Taxes (line 30 minus line 40)**	(241,280)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (241,280)	43

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

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

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

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

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning:

01/01/09

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	2,000	2,028	\$ 100,190	\$ 49.40	1
2	Assistant Director of Nursing	3,329	4,150	175,824	42.37	2
3	Registered Nurses	17,568	18,859	515,625	27.34	3
4	Licensed Practical Nurses	48,549	51,759	1,416,750	27.37	4
5	CNAs & Orderlies	104,159	112,346	1,634,822	14.55	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,408	10,116	86,649	8.57	8
9	Activity Director	1,914	2,358	30,513	12.94	9
10	Activity Assistants	11,094	12,487	151,984	12.17	10
11	Social Service Workers	27,015	28,846	439,529	15.24	11
12	Dietician	2,043	2,214	35,861	16.20	12
13	Food Service Supervisor	2,503	2,868	68,361	23.84	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,318	28,282	392,926	13.89	15
16	Dishwashers	13,986	15,359	148,297	9.66	16
17	Maintenance Workers	27,583	29,428	250,947	8.53	17
18	Housekeepers	29,958	32,490	384,133	11.82	18
19	Laundry	9,809	10,732	152,207	14.18	19
20	Administrator	3,088	3,261	168,643	51.72	20
21	Assistant Administrator	960	1,044	44,657	42.77	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,340	9,036	162,600	17.99	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	5,870	6,556	118,139	18.02	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	354,494	384,219	\$ 6,478,657 *	\$ 16.86	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	Monthly	\$ 125	01-03	35
36	Medical Director	Monthly	19,800	09-03	36
37	Medical Records Consultant	Monthly	4,400	10-03	37
38	Nurse Consultant	12	748	10-03	38
39	Pharmacist Consultant	Monthly	5,113	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	18	1,095	11-03	44
45	Social Service Consultant	97	5,784	12-03	45
46	Other(specify)				46
47	<u>Psychiatrist</u>	Monthly	6,000	10-03	47
48	<u>See Attached</u>		20,400		48
49	TOTAL (lines 35 - 48)	127	\$ 63,465		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	8	\$ 364	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	8	\$ 364		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	
<u>Moira Tannen (Jan-May)</u>	<u>Administrator</u>	<u>0.00%</u>	<u>\$ 10,549</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 111,847</u>	<u>IDPH License Fee</u>	<u>\$ 995</u>	
<u>Serena Carter (Jan-May)</u>	<u>Asst. Admin.</u>	<u>0.00%</u>	<u>27,069</u>	<u>Unemployment Compensation Insurance</u>	<u>110,959</u>	<u>Advertising: Employee Recruitment</u>	<u>11,809</u>	
<u>Shimon Webster (Jun- Dec)</u>	<u>Administrator</u>	<u>32.47%</u>	<u>79,055</u>	<u>FICA Taxes</u>	<u>472,874</u>	<u>Health Care Worker Background Check</u>		
<u>Yeruchom Levovitz (Jun- Dec)</u>	<u>Administrator</u>	<u>30.31%</u>	<u>79,055</u>	<u>Employee Health Insurance</u>	<u>278,850</u>	<u>(Indicate # of checks performed <u>56</u>)</u>	<u>1,231</u>	
<u>Moshe Levovitz (Jun-Dec)</u>	<u>Asst. Admin.</u>	<u>0.00%</u>	<u>17,572</u>	<u>Employee Meals</u>		<u>Patient Background Checks <u>354</u></u>	<u>3,535</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Licenses & Fees</u>	<u>12,332</u>	
				<u>Pension Expenses</u>	<u>40,250</u>	<u>Dues & Subscriptions</u>	<u>3,090</u>	
				<u>Other Employee Benefits</u>	<u>24,045</u>	<u>Advertising & Promotions</u>	<u>3,512</u>	
				<u>Christmas Expense</u>	<u>8,859</u>	<u>Allocated From Ext. Care Consulting</u>	<u>1,952</u>	
				<u>Employee Physicals</u>	<u>1,353</u>	<u>See Supplemental Schedule</u>	<u>30</u>	
						<u>Less: Public Relations Expense</u>	<u>()</u>	
						<u>Non-allowable advertising</u>	<u>(3,512)</u>	
						<u>Yellow page advertising</u>	<u>()</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 213,300	TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,049,037	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 34,974	
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Management Fees- Shimon Webster</u>			<u>\$ 87,500</u>				<u>Out-of-State Travel</u>	<u>\$</u>
<u>Management Fees- Yeruchom Levovitz</u>			<u>87,500</u>					
							<u>In-State Travel</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 175,000	TOTAL		\$	<u>Seminar Expense</u>	<u>5,079</u>
(Attach a copy of any management service agreement)							<u>Allocated From Ext. Care Consulting</u>	<u>61</u>
							<u>Allocated From Ext. Care Clinical</u>	<u>936</u>
							<u>Entertainment Expense</u>	<u>()</u>
							<u>(agree to Sch. V, line 24, col. 8)</u>	
							TOTAL	\$ 6,076
C. Professional Services								
Vendor/Payee	Type		Amount					
<u>See Attached</u>	<u>Legal</u>		<u>\$ 60,640</u>					
<u>Frost, Ruttenberg & Rothblatt</u>	<u>Accounting</u>		<u>39,422</u>					
<u>New York Boys Management</u>	<u>Accounting</u>		<u>5,000</u>					
<u>First Real Estate Services</u>	<u>Real Estate Appraisal</u>		<u>2,750</u>					
<u>Commonwealth Edison</u>	<u>Energy Upgrades</u>		<u>1,996</u>					
<u>Personnel Planners</u>	<u>Unemployment Consult</u>		<u>1,758</u>					
<u>Extended Care Consulting</u>	<u>Home Office Expenses</u>		<u>131,249</u>					
<u>Paycor</u>	<u>Payroll Services</u>		<u>13,012</u>					
<u>ADP</u>	<u>Payroll Services</u>		<u>500</u>					
<u>E- Health Data Solutions</u>	<u>MDS Data Processing</u>		<u>795</u>					
<u>National Datacare Corp</u>	<u>Resident Fund Processing</u>		<u>3,224</u>					
<u>See Supplemental Schedule</u>			<u>22,942</u>					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 283,289					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* 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																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS			\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Westshire Nursing & Rehab Ctr

0042325

Report Period Beginning: 01/01/09

Ending: 12/31/09

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ILCLTC \$1,850
- (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. \$ 15,842 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 265,538
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (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.