

Facility Name & ID Number SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.

0040444 Report Period Beginning: 01/01/00 Ending: 12/31/00

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 _____

	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	127	Skilled (SNF)	127	46,482	1
2		Skilled Pediatric (SNF/PED)			2
3	61	Intermediate (ICF)	61	22,326	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	188	TOTALS	188	68,808	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		Public Aid Recipient	Private Pay	Other		
8	SNF	12,872	407	2,599	15,878	8
9	SNF/PED					9
10	ICF	45,904	949		46,853	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	58,776	1,356	2,599	62,731	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.17%

D. How many bed-hold days during this year were paid by Public Aid? 1,070 (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 5/1/93

J. Was the facility purchased or leased after January 1, 1978?
YES Date 5/1/93 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 31 and days of care provided 1,736

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/00 Fiscal Year: 12/31/00

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

Facility Name & ID Number SHERIDAN SHORES CARE & REHABILITATION # 0040444 Report Period Beginning: 01/01/00 Ending: 12/31/00

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	200,292	31,206	17,722	249,220		249,220	(8,821)	240,399		1
2	Food Purchase		226,967		226,967	(26,645)	200,322	3,636	203,959		2
3	Housekeeping	135,661	30,807		166,468		166,468	2,227	168,695		3
4	Laundry	54,376	24,301		78,677		78,677		78,677		4
5	Heat and Other Utilities			158,871	158,871		158,871	1,709	160,580		5
6	Maintenance	49,932		235,196	285,128		285,128	(44,240)	240,888		6
7	Other (specify):*							2,377	2,377		7
8	TOTAL General Services	440,261	313,281	411,789	1,165,331	(26,645)	1,138,686	(43,111)	1,095,575		8
	B. Health Care and Programs										
9	Medical Director			9,950	9,950		9,950		9,950		9
10	Nursing and Medical Records	2,145,870	113,085	46,843	2,305,798		2,305,798	9,689	2,315,487		10
10a	Therapy	79,581	2,338	22,907	104,826		104,826	(8,940)	95,886		10a
11	Activities	122,704	8,696	5,109	136,509		136,509	(817)	135,692		11
12	Social Services	72,094		5,398	77,492		77,492	23	77,515		12
13	Nurse Aide Training			885	885		885		885		13
14	Program Transportation										14
15	Other (specify):*							4,648	4,648		15
16	TOTAL Health Care and Programs	2,420,249	124,119	91,092	2,635,460		2,635,460	4,602	2,640,062		16
	C. General Administration										
17	Administrative	7,276		80,884	88,160		88,160	19,158	107,318		17
18	Directors Fees										18
19	Professional Services			323,589	323,589	(19,000)	304,589	(259,379)	45,210		19
20	Dues, Fees, Subscriptions & Promotions			74,691	74,691		74,691	(31,226)	43,465		20
21	Clerical & General Office Expenses	95,909	26,207	123,625	245,741		245,741	35,039	280,780		21
22	Employee Benefits & Payroll Taxes			532,184	532,184	26,645	558,829	(29,004)	529,825		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,044	4,044		4,044	4,835	8,879		24
25	Other Admin. Staff Transportation			826	826		826	437	1,263		25
26	Insurance-Prop.Liab.Malpractice			143,987	143,987		143,987	1,138	145,125		26
27	Other (specify):*							28,581	28,581		27
28	TOTAL General Administration	103,185	26,207	1,283,830	1,413,222	7,645	1,420,867	(230,420)	1,190,447		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,963,695	463,607	1,786,711	5,214,013	(19,000)	5,195,013	(268,930)	4,926,083		29

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

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

SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.

0040444

COST REPORT RECLASSIFICATIONS

01/01/00

12/31/00

SCHEDULE V
LINE #

22	EMPLOYEE BENEFITS	<u>26,645</u>	
2	FOOD		<u>26,645</u>

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	<u>19,000</u>	
19	PROFESSIONAL FEES		<u>19,000</u>

To reclass cost of appealing real estate taxes

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			112,289	112,289		112,289	(22,622)	89,667			30
31	Amortization of Pre-Op. & Org.			991	991		991	9,759	10,750			31
32	Interest			196,202	196,202		196,202	28,809	225,011			32
33	Real Estate Taxes			282,777	282,777	19,000	301,777	2,314	304,091			33
34	Rent-Facility & Grounds			994,994	994,994		994,994	(1,922)	993,072			34
35	Rent-Equipment & Vehicles			3,688	3,688		3,688	3,652	7,340			35
36	Other (specify):*											36
37	TOTAL Ownership			1,590,941	1,590,941	19,000	1,609,941	19,990	1,629,931			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	175,870	252,127	29,359	457,356		457,356	(46,067)	411,289			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			103,212	103,212		103,212		103,212			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	175,870	252,127	132,571	560,568		560,568	(46,067)	514,501			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,139,565	715,734	3,510,223	7,365,522		7,365,522	(295,007)	7,070,515			45

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

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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(6,347)	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(85,452)	30		9
10	Interest and Other Investment Income	(98)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(48)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(349)	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	(66,000)	21		24
25	Fund Raising, Advertising and Promotional	(14,475)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(646)	20		28
29	Other-Attach Schedule	(1,928)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (175,343)		\$	30

OHF USE ONLY							
48		49		50		51	
						52	

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)	(119,664)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (119,664)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (295,007)		37

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

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

(See instructions.)

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

ID# 0040444
 Report Period Beginning: 01/01/00
 Ending: 12/31/00

	Amount	Sch. V Line Reference
1		6
2		21
3		21
4		21
5		5
6		24
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80		80
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87		87
88		88
89		89
90		90
Total	(1,928)	

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SHERIDAN SHORES CARE & REHABILITATION CEN# 0040444

Report Period Beginning:

01/01/00

Ending:

12/31/00

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			5,315	(6,862)		(7,274)						(8,821)	1
2	Food Purchase	(48)		(1,131)			4,815						3,636	2
3	Housekeeping			2,227									2,227	3
4	Laundry													4
5	Heat and Other Utilities			1,709									1,709	5
6	Maintenance			13,984	(58,246)		22						(44,240)	6
7	Other (specify):*			2,140			237						2,377	7
8	TOTAL General Services	(48)		24,245	(65,108)		(2,200)						(43,111)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(60)		26,972	(9,781)		4			(7,446)			9,689	10
10a	Therapy			5,210	(14,150)								(8,940)	10a
11	Activities			2,260	(3,077)								(817)	11
12	Social Services			1,992	(1,969)								23	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			4,648									4,648	15
16	TOTAL Health Care and Programs	(60)		41,082	(28,978)		4			(7,446)			4,602	16
	C. General Administration													
17	Administrative			35,964	(80,710)	63,779	125						19,158	17
18	Directors Fees													18
19	Professional Services			9,469	(268,885)		37						(259,379)	19
20	Fees, Subscriptions & Promotions	(15,470)		1,390	(17,155)		9						(31,226)	20
21	Clerical & General Office Expenses	(67,743)		128,084	(25,426)		124						35,039	21
22	Employee Benefits & Payroll Taxes				(29,004)								(29,004)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(125)		4,952			8						4,835	24
25	Other Admin. Staff Transportation			220			217						437	25
26	Insurance-Prop.Liab.Malpractice			1,138									1,138	26
27	Other (specify):*			18,923		9,658							28,581	27
28	TOTAL General Administration	(83,338)		200,140	(421,179)	73,437	520						(230,420)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(83,446)		265,467	(515,265)	73,437	(1,676)			(7,446)			(268,930)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SHERIDAN SHORES CARE & REHABILITATION CEN7 # 0040444 Report Period Beginning: 01/01/00 Ending: 12/31/00

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)	
30	D. Ownership													
	Depreciation	(85,452)		11,950					50,880				(22,622)	30
31	Amortization of Pre-Op. & Org.		9,759										9,759	31
32	Interest	(98)		12,938			7		15,962				28,809	32
33	Real Estate Taxes			2,314									2,314	33
34	Rent-Facility & Grounds	(6,347)		4,425									(1,922)	34
35	Rent-Equipment & Vehicles			3,641			11						3,652	35
36	Other (specify):*													36
37	TOTAL Ownership	(91,897)	9,759	35,268			18		66,842				19,990	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(1,547)		(44,520)				(46,067)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers						(1,547)		(44,520)				(46,067)	44
45	GRAND TOTAL COST													
	(sum of lines 29, 37 & 44)	(175,343)	9,759	300,735	(515,265)	73,437	(3,205)		22,322	(7,446)			(295,007)	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		
				Edgewater Care & Rehab Bldg, LLC		Building Co.

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	34 Rental Income / Expense	\$ 994,994	Edgewater Care & Rehabilitation Center Bldg, LLC	100.00%	\$ 994,994	\$	1	
2	V	32 Rental Inc. / Exp. - RE Tax	299,010	Edgewater Care & Rehabilitation Center Bldg, LLC	100.00%	299,010		2	
3	V	31 Amortization		Edgewater Care & Rehabilitation Center Bldg, LLC	100.00%	9,759	9,759	3	
4	V							4	
5	V							5	
6	V							6	
7	V							7	
8	V							8	
9	V							9	
10	V							10	
11	V							11	
12	V							12	
13	V							13	
14	Total		\$ 1,294,004			\$ 1,303,763	\$ *	9,759	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 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization		8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization						
15	V	1	DIETARY	\$	CARE CENTERS, INC.	100.00%	\$ 5,315	\$	5,315	15
16	V	2	FOOD				(1,131)		(1,131)	16
17	V	3	HOUSEKEEPING				2,227		2,227	17
18	V	5	UTILITIES				1,709		1,709	18
19	V	6	REPAIRS AND MAINT.				13,984		13,984	19
20	V	7	EMP. BEN. - GEN. SERV.				2,140		2,140	20
21	V	10	NURSING				26,972		26,972	21
22	V	10A	THERAPY				5,210		5,210	22
23	V	11	ACTIVITIES				2,260		2,260	23
24	V	12	SOCIAL SERVICES				1,992		1,992	24
25	V	15	EMP. BEN. - HEALTHCARE				4,648		4,648	25
26	V	17	ADMINISTRATIVE				35,964		35,964	26
27	V	19	PROFESSIONAL FEES				9,469		9,469	27
28	V	20	DUES, SUBSCRIPTIONS				1,390		1,390	28
29	V	21	CLERICAL AND GENERAL				128,084		128,084	29
30	V	24	SEMINARS				4,952		4,952	30
31	V	25	AUTO EXPENSE				220		220	31
32	V	26	INSURANCE				1,138		1,138	32
33	V	27	EMP. BEN. - GEN. ADMIN.				18,923		18,923	33
34	V	30	DEPRECIATION				11,950		11,950	34
35	V	32	INTEREST	0			12,938		12,938	35
36	V	33	REAL ESTATE TAXES				2,314		2,314	36
37	V	34	BUILDING RENT - UNRELATED				4,425		4,425	37
38	V	35	EQUIPMENT RENTAL				3,641		3,641	38
39	Total			\$			\$ 300,735	\$ *	300,735	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 CONS	\$ 6,862	0	100.00%	\$ 0	\$	(6,862)	15
16	V	19 ACCOUNTING	15,000			0		(15,000)	16
17	V	19 ANCIL ADMIN FEE	22,560			0		(22,560)	17
18	V	19 BOOKEEPING	38,352			0		(38,352)	18
19	V	19 DATA PROCESSING	6,768			0		(6,768)	19
20	V	19 LEGAL	24,870			0		(24,870)	20
21	V	19 MANAGEMENT FEE	157,920			0		(157,920)	21
22	V	19 PROFESSIONAL FEES	3,415			0		(3,415)	22
23	V	20 ADVERTISING	17,155			0		(17,155)	23
24	V	25 REBILL BUS	0			0			24
25	V	0				0			25
26	V	22 HOME OFFICE PAYROLL TAX	29,004			0		(29,004)	26
27	V	1 REBILL. PAYROLL DIETARY	0			0			27
28	V	3 REBILL. PAYROLL HSKPNG	0			0			28
29	V	6 REBILL. PAYROLL MAINT.	58,246			0		(58,246)	29
30	V	10 REBILL. PAYROLL NURSING	9,781			0		(9,781)	30
31	V	10A REBILL. PAYROLL THPY CONS.	14,150			0		(14,150)	31
32	V	11 REBILL. PAYROLL ACTIVITIES	3,077			0		(3,077)	32
33	V	12 REBILL. PAYROLL SOC. SERV.	1,969			0		(1,969)	33
34	V	17 REBILL. PAYROLL ADMIN.	80,710			0		(80,710)	34
35	V	21 REBILL. PAYROLL CLERICAL	25,426			0		(25,426)	35
36	V								36
37	V								37
38	V								38
39	Total		\$ 515,265			\$ 0	\$ *	(515,265)	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	10 NURSING	\$	CARE CENTERS, INC.	100.00%	\$ 0	\$	15	
16	V	15 EMP. BEN HEALTHCARE				0		16	
17	V	17 ADMINISTRATIVE				63,779	63,779	17	
18	V	27 EMP. BEN GEN. ADMIN.				9,658	9,658	18	
19	V	0				0		19	
20	V	0				0		20	
21	V	0				0		21	
22	V	0				0		22	
23	V	0				0		23	
24	V	0				0		24	
25	V	0				0		25	
26	V	0				0		26	
27	V	0				0		27	
28	V	0				0		28	
29	V	0				0		29	
30	V	0				0		30	
31	V	0				0		31	
32	V	0				0		32	
33	V	0				0		33	
34	V	0						34	
35	V	0	0					35	
36	V							36	
37	V							37	
38	V							38	
39	Total		\$			\$ 73,437	\$ *	73,437	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	\$	CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	\$ 2,487	\$	2,487	15
16	V	2 FOOD				4,815		4,815	16
17	V	6 MAINTENANCE				22		22	17
18	V	7 EMP. BEN. - GEN. SERV.				237		237	18
19	V	10 NURSING				4		4	19
20	V	17 ADMINISTRATIVE				125		125	20
21	V	19 PROFESSIONAL FEES				37		37	21
22	V	20 DUES, FEES, SUB.				9		9	22
23	V	21 CLERICAL & GENERAL				124		124	23
24	V	24 SEMINARS				8		8	24
25	V	25 TRAVEL				217		217	25
26	V	32 INTEREST				7		7	26
27	V	35 RENT - EQUIPMENT & VEHICLES				11		11	27
28	V	39 ANCILLARY ENTERAL SUPPLIES				162		162	28
29	V	1 DIETARY SUPP	9,761			0		(9,761)	29
30	V	39 ANCILLARY SUPP	1,709			0		(1,709)	30
31	V	0				0			31
32	V	0				0			32
33	V	0				0			33
34	V	0							34
35	V	0	0						35
36	V								36
37	V								37
38	V								38
39	Total		\$ 11,470			\$ 8,265	\$ *	(3,205)	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	21 CLERICAL AND GENERAL	\$	CARE CENTERS, INC.	100.00%	\$ 0	\$	15
16	V	27 EMP. BEN. - GEN. SERV. EMP. BEN.				0		16
17	V	0				0		17
18	V	0				0		18
19	V	0				0		19
20	V	0				0		20
21	V	0				0		21
22	V	0				0		22
23	V	0				0		23
24	V	0				0		24
25	V	0				0		25
26	V	0				0		26
27	V	0				0		27
28	V	0				0		28
29	V	0				0		29
30	V	0				0		30
31	V	0				0		31
32	V	0				0		32
33	V	0				0		33
34	V	0						34
35	V	0	0					35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	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 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
15	V	30	DEPRECIATION	\$	VENTLEASE LLC	100.00%	\$ 50,880	\$ 50,880	15
16	V	32	INTEREST				15,962	15,962	16
17	V								17
18	V								18
19	V	39	ANCILLARY EQUIP RENT	44,520				(44,520)	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			\$ 44,520			\$ 66,842	\$ * 22,322	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 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
15	V	10	MEDICALSUPPLIES	\$	XCEL MEDICAL SUPPLY LLC	100.00%	\$ 39,255	\$ 39,255	15
16	V								16
17	V								17
18	V								18
19	V	10	MEDICALSUPPLIES	46,701				(46,701)	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			\$ 46,701			\$ 39,255	\$ * (7,446)	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 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
15	V	22	EMPLOYEE HEALTH INS.	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 111,102	\$ 111,102	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	111,102				(111,102)	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			\$ 111,102			\$ 111,102	\$ *	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 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name 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		\$				\$	0 \$ *	39

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

Facility Name & ID Number SHERIDAN SHORES CARE & REHABIL # 0040444 Report Period Beginning: 01/01/00 Ending: 12/31/00

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	3.19	see attached	2.03	2.82		\$			1
2	Norm Goldberg	Owner	Administrative	2.13	see attached	2.07	4.14	salary alloc.	3,769	17-7		2
3	Jim Goodsite	Owner	CFO	2.13	see attached	2.07	4.14	salary alloc.	5,399	17-7		3
4	Mark Steinberg	Relative	Administrative		see attached	2.07	4.14	salary alloc.	1,840	17-7		4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13								TOTAL	\$ 11,008			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.

Facility Name & ID Number SHERIDAN SHORES CARE & REHABILITATION CE # 0040444 Report Period Beginning: 01/01/00 Ending: 12/31/00

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

Facility Name & ID Number SHERIDAN SHORES CARE & REHABILITATION CE # 0040444 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CARE CENTERS, INC.
 Street Address 150 FENCL LANE
 City / State / Zip Code HILLSIDE, IL. 60162
 Phone Number (708)449-9090
 Fax Number (708)449-7070

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	1,512,231	32	\$ 128,135	\$ 128,055	62,731	\$ 5,315	1
2	2	FOOD	1,512,231	32	(27,254)		62,731	(1,131)	2
3	3	HOUSEKEEPING	1,512,231	32	53,695	52,345	62,731	2,227	3
4	5	UTILITIES	1,512,231	32	41,192		62,731	1,709	4
5	6	REPAIRS AND MAINT.	1,512,231	32	337,107	220,731	62,731	13,984	5
6	7	EMP. BEN. - GEN. SERV.	1,512,231	32	51,593		62,731	2,140	6
7	10	NURSING	1,512,231	32	650,209	657,173	62,731	26,972	7
8	10A	THERAPY	1,512,231	32	125,600	125,524	62,731	5,210	8
9	11	ACTIVITIES	1,512,231	32	54,474	54,163	62,731	2,260	9
10	12	SOCIAL SERVICES	1,512,231	32	48,011	48,011	62,731	1,992	10
11	15	EMP. BEN. - HEALTHCARE	1,512,231	32	112,058		62,731	4,648	11
12	17	ADMINISTRATIVE	1,512,231	32	866,963	862,068	62,731	35,964	12
13	19	PROFESSIONAL FEES	1,512,231	32	228,254		62,731	9,469	13
14	20	DUES, SUBSCRIPTIONS	1,512,231	32	33,513		62,731	1,390	14
15	21	CLERICAL AND GENERAL	1,512,231	32	3,087,659	2,709,599	62,731	128,084	15
16	24	SEMINARS	1,512,231	32	119,372		62,731	4,952	16
17	25	AUTO EXPENSE	1,512,231	32	5,310		62,731	220	17
18	26	INSURANCE	1,512,231	32	27,429		62,731	1,138	18
19	27	EMP. BEN. - GEN. ADMIN.	1,512,231	32	456,163		62,731	18,923	19
20	30	DEPRECIATION	1,512,231	32	288,068		62,731	11,950	20
21	32	INTEREST	1,512,231	32	311,903		62,731	12,938	21
22	33	REAL ESTATE TAXES	1,512,231	32	55,780		62,731	2,314	22
23	34	BUILDING RENT - UNRELATE	1,512,231	32	106,673		62,731	4,425	23
24	35	EQUIPMENT RENTAL	1,512,231	32	87,772		62,731	3,641	24
25	TOTALS				\$ 7,249,679	\$ 4,857,669		\$ 300,735	25

Facility Name & ID Number SHERIDAN SHORES CARE & REHABILITATION CE # 0040444 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CARE CENTERS, INC.
 Street Address 150 FENCL LANE
 City / State / Zip Code HILLSIDE, IL. 60162
 Phone Number (708)449-9090
 Fax Number (708)449-7070

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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

Facility Name & ID Number SHERIDAN SHORES CARE & REHABILITATION CE # 0040444 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CARE CENTERS, INC.
 Street Address 150 FENCL LANE
 City / State / Zip Code HILLSIDE, IL. 60162
 Phone Number (708)449-9090
 Fax Number (708)449-7070

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT ALLOCATION	9	307,262	298,696			1
2	15	EMP. BEN HEALTHCARE	DIRECT ALLOCATION	9	39,980				2
3	17	ADMINISTRATIVE	DIRECT ALLOCATION	24	1,436,904	1,436,850		63,779	3
4	27	EMP. BEN GEN. ADMIN.	DIRECT ALLOCATION	24	191,316			9,658	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				\$ 1,975,462	\$ 1,735,546		\$ 73,437	25

Facility Name & ID Number SHERIDAN SHORES CARE & REHABILITATION CE # 0040444 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CARE CENTERS, INC.
 Street Address 150 FENCL LANE
 City / State / Zip Code HILLSIDE, IL. 60162
 Phone Number (708)449-9090
 Fax Number (708)449-7070

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	HEALTH SYSTEMS INC. 2,287,765	28	496,134	378,284	11,470	2,487	1
2	2	FOOD	HEALTH SYSTEMS INC. 2,287,765	28	960,501		11,470	4,815	2
3	6	MAINTENANCE	HEALTH SYSTEMS INC. 2,287,765	28	4,392		11,470	22	3
4	7	EMP. BEN. - GEN. SERV.	HEALTH SYSTEMS INC. 2,287,765	28	47,282		11,470	237	4
5	10	NURSING	HEALTH SYSTEMS INC. 2,287,765	28	700		11,470	4	5
6	17	ADMINISTRATIVE	HEALTH SYSTEMS INC. 2,287,765	28	25,000		11,470	125	6
7	19	PROFESSIONAL FEES	HEALTH SYSTEMS INC. 2,287,765	28	7,428		11,470	37	7
8	20	DUES, FEES, SUB.	HEALTH SYSTEMS INC. 2,287,765	28	1,836		11,470	9	8
9	21	CLERICAL & GENERAL	HEALTH SYSTEMS INC. 2,287,765	28	24,796		11,470	124	9
10	24	SEMINARS	HEALTH SYSTEMS INC. 2,287,765	28	1,526		11,470	8	10
11	25	TRAVEL	HEALTH SYSTEMS INC. 2,287,765	28	43,326		11,470	217	11
12	32	INTEREST	HEALTH SYSTEMS INC. 2,287,765	28	1,489		11,470	7	12
13	35	RENT - EQUIPMENT & VEHIC	HEALTH SYSTEMS INC. 2,287,765	28	2,182		11,470	11	13
14	39	ANCILLARY ENTERAL SUPPL	HEALTH SYSTEMS INC. 2,287,765	28	32,397		11,470	162	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,648,989	\$ 378,284		\$ 8,265	25

Facility Name & ID Number SHERIDAN SHORES CARE & REHABILITATION CE # 0040444 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CARE CENTERS, INC.
 Street Address 150 FENCL LANE
 City / State / Zip Code HILLSIDE, IL. 60162
 Phone Number (708)449-9090
 Fax Number (708)449-7070

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	CLERICAL AND GENERAL	DIRECT ALLOCATION	100	1	31,075	31,075		1
2	27	EMP. BEN. - GEN. SERV. EMP.	DIRECT ALLOCATION	100	1	4,401			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					\$ 35,476	\$ 31,075		\$ 25

Facility Name & ID Number SHERIDAN SHORES CARE & REHABILITATION CE # 0040444 Report Period Beginning: 01/01/00 Ending: 12/31/00

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 VENTLEASE LLC
 Street Address 4101 W. MAIN ST.
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 674-1180
 Fax Number (847) 673-7741

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION			\$	\$		50,880	1
2	32	INTEREST						15,962	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				\$	\$		66,842	25

Facility Name & ID Number SHERIDAN SHORES CARE & REHABILITATION CE # 0040444 Report Period Beginning: 01/01/00 Ending: 12/31/00

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 MEDICAL SUPPLY LLC
 Street Address 150 FENCL LANE
 City / State / Zip Code HILLSIDE, IL. 60162
 Phone Number (708)449-2330
 Fax Number (708)449-3236

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	MEDICALSUPPLIES	DIRECT ALLOCATION		\$	\$		\$ 39,255	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				\$	\$		\$ 39,255	25

Facility Name & ID Number SHERIDAN SHORES CARE & REHABILITATION CE # 0040444 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CCS EMPLOYEE BENEFITS GROUP, INC.
 Street Address 4101 W. MAIN ST.
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 674-1180
 Fax Number (847) 673-7741

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION		\$	\$		\$ 111,102	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				\$	\$		\$ 111,102	25

Facility Name & ID Number SHERIDAN SHORES CARE & REHABILITATION CE # 0040444 Report Period Beginning: 01/01/00 Ending: 12/31/00

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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

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						\$	\$			\$	1								
2											2								
3											3								
4											4								
5											5								
Working Capital																			
6	Shareholders Loans	X		Working Capital			585,000			52,690	6								
7											7								
8	Diawa		X	Line of Credit			2,389,057			143,512	8								
9	TOTAL Facility Related					\$	\$ 2,974,057			\$ 196,202	9								
B. Non-Facility Related*																			
10	Supplemental Schedule									28,809	10								
11											11								
12											12								
13											13								
14	TOTAL Non-Facility Related					\$	\$			\$ 28,809	14								
15	TOTALS (line 9+line14)					\$	\$ 2,974,057			\$ 225,011	15								

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

(See instructions.)

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

(See instructions.)

Facility Name & ID Number SHERIDAN SHORES CARE & REHABILITA # 0040444 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10	Reporting Period Interest Expense	1				
		Related**					Monthly Payment Required	Date of Note							Amount of Note		Maturity Date	Interest Rate (4 Digits)
		YES	NO												Original	Balance		
1	Interest Income						\$	\$					\$ (98)	1				
2	Care Center Allocation	x											12,945	2				
3	Ventlease Allocation	x											15,962	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							\$	\$					\$ 28,809	21				

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	\$	301,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	287,083	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(13,917)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	299,008	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$	19,000	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	304,091	7

Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1995	294,288	8
	1996	301,529	9
	1997	285,880	10
	1998	286,694	11
	1999	284,769	12

2000 Accrual = 1999 Tax plus 5%			
\$284,769.16 x 105% = \$299,008			
RE Tax allocated from Related Parties: \$2314			

FOR OFF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION\$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 74,000 B. General Construction Type: Exterior Brick 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, nurse aide 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: 82,955 2. Number of Years Over Which it is Being Amortized: various

3. Current Period Amortization: 10,750 4. Dates Incurred: various

Nature of Costs: Prepaid assignment fees, financing fees

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
	<u>Care Center Alloc</u>		<u>1996</u>	<u>\$ 2,655</u>	1
					2
	TOTALS			\$ 2,655	3

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1993		42,874	1,526	20	2,145	619	15,733	9
10	Various		1994		57,552	1,718	20	2,878	1,160	18,933	10
11	Various		1995		146,433	3,754	20	7,322	3,568	41,400	11
12	PLUMBING RENOV		1996		1,235	32	20	62	30	284	12
13	PLUMBING RENOV		1996		999	26	20	50	24	246	13
14	PAINTING & DEC		1996		1,000	26	20	50	24	229	14
15	ELECTRICAL RENOV		1996		3,003	77	20	150	73	700	15
16	CONDENSOR RENOV		1996		980	25	20	49	24	233	16
17	GARAGE DOOR		1996		1,595	41	20	80	39	387	17
18	NEW MOTOR		1996		748	86	20	37	(49)	74	18
19	FIRE ALARM		1996		47,949	1,229	20	2,397	1,168	11,386	19
20	ELEVATOR RENOV		1996		1,255	32	20	63	31	315	20
21	HVAC RENOV		1996		1,388	36	20	69	33	322	21
22	HVAC RENOV		1996		800	21	20	40	19	173	22
23	HVAC RENOV		1996		850	22	20	43	21	190	23
24											24
25	PAGE 12-I REP TOTALS				59,146	1,575		1,961	386	7,878	25
26											26
27											27
28											28
29											29
30	PAGE 12F TOTALS				8,341	1,410		351	(1,059)	351	30
31	PAGE 12E TOTALS				99,461	11,018		2,911	(8,107)	2,911	31
32	PAGE 12D TOTALS				67,064	2,769		3,113	344	3,822	32
33	PAGE 12C TOTALS				85,165	2,390		4,259	1,869	9,166	33
34	PAGE 12B TOTALS				124,855	3,203		6,245	3,042	16,174	34
35	PAGE 12A TOTALS				59,804	1,688		2,991	1,303	10,579	35
36	TOTAL (lines 4 thru 35)				\$ 812,497	\$ 32,704		\$ 37,266	\$ 4,562	\$ 141,486	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.

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	DOOR		1996		1,225	109	20	61	(48)	122	9
10	CURTAINS		1996		447	40	20	22	(18)	44	10
11	COOLER RENOV		1996		542	63	20	27	(36)	54	11
12	HVAC RENOV		1996		950	24	20	48	24	200	12
13	ELECTRICAL RENOV		1996		2,738	70	20	137	67	594	13
14	HVAC RENOV		1997		1,556	40	20	78	38	260	14
15	ROOF RENOVATION		1997		8,350	214	20	418	204	1,533	15
16	DRAPERY		1997		2,018	52	20	101	49	370	16
17	SPRINKLER SYSTEM		1997		2,935	75	20	147	72	551	17
18	BOILER RENOVATION		1997		1,159	30	20	58	28	222	18
19	BOILER RENOVATION		1997		577	15	20	29	14	114	19
20	DOOR MONITOR SYS		1997		2,737	70	20	137	67	537	20
21	HVAC RENOVATION		1997		5,307	136	20	265	129	950	21
22	BLDG RENOVATION		1997		1,500	38	20	75	37	300	22
23	PLUMBING RENOV		1997		952	24	20	48	24	172	23
24	HVAC RENOV		1997		651	17	20	33	16	102	24
25	FIRE ALARM		1997		3,500	90	20	175	85	700	25
26	ELECTRICAL RENOV		1997		1,307	34	20	65	31	233	26
27	HVAC RENOV		1997		553	14	20	28	14	96	27
28	HVAC RENOVATION		1997		1,245	32	20	62	30	217	28
29	PAINTING & DECORATIN		1997		606	16	20	30	14	95	29
30	SPRINKLER SYSTEM		1997		8,980	230	20	449	219	1,422	30
31	FIRE ALARM		1997		6,285	161	20	314	153	1,021	31
32	TILE		1997		1,246	32	20	62	30	207	32
33	ELECTRICAL RENOV		1997		740	19	20	37	18	130	33
34	SPRINKLER SYS REN		1997		900	23	20	45	22	173	34
35	BOILER RENOVATION		1997		798	20	20	40	20	160	35
36	TOTAL (lines 4 thru 35)				\$ 59,804	\$ 1,688		\$ 2,991	\$ 1,303	\$ 10,579	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.

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	FIRE DOORS		1998		1,885	48	20	94	46	251	9
10					15,000	385		750	365	2,063	10
11	PLUMBING RENOV		1998		844	22	20	42	20	123	11
12	BOILER RENOV		1998		2,560	66	20	128	62	373	12
13	DOORS		1998		3,200	82	20	160	78	453	13
14	HINDGES		1998		2,579	66	20	129	63	366	14
15	WALLPAPER		1998		3,673	94	20	184	90	521	15
16	ELEVATOR RENOV		1998		1,508	39	20	75	36	225	16
17	FIRE DOOR		1998		2,555	66	20	128	62	331	17
18	DOOR CLOSURES		1998		3,129	80	20	156	76	429	18
19	ELEV RENOV		1998		533	14	20	27	13	74	19
20	FIRE DAMPERS		1998		9,799	251	20	490	239	1,348	20
21	HVAC RENOV		1998		3,794	97	20	190	93	507	21
22	FISH TANK		1998				20				22
23	DRYWALL		1998		8,250	212	20	413	201	1,101	23
24	HEAT DAMPERS		1998		7,950	204	20	398	194	1,028	24
25	DRYWALL		1998		7,200	185	20	360	175	930	25
26	SECURITY SYS		1998		3,195	82	20	160	78	427	26
27	DRYWALL		1998		4,000	103	20	200	97	467	27
28	FIRE DAMPERS		1998		9,240	237	20	462	225	1,194	28
29	ELEVATOR RENOV		1998		776	20	20	39	19	98	29
30	DRYWALL		1998		3,800	97	20	190	93	396	30
31	DRYWALL		1998		9,500	244	20	475	231	1,148	31
32	PLUMBING RENOV		1998		5,530	142	20	277	135	669	32
33	HVAC RENOV		1998		642	16	20	32	16	77	33
34	SMOKE DETECTION		1998		7,000	179	20	350	171	875	34
35	BOILER TUBES		1998		6,713	172	20	336	164	700	35
36	TOTAL (lines 4 thru 35)				\$ 124,855	\$ 3,203		\$ 6,245	\$ 3,042	\$ 16,174	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.

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		METAL DOOR	1998		1,656	42	20	83	41	201	9
10		WALLPAPER	1998		941	24	20	47	23	102	10
11		PLUMBING RENOV	1998		2,679	69	20	134	65	313	11
12		LIFE SAFETY CODE	1998		6,000	154	20	300	146	675	12
13		WALLPAPER	1998		6,000	154	20	300	146	825	13
14		GENERATOR	1998		1,158	30	20	58	28	121	14
15		TRANSMITTER	1998		876	22	20	44	22	92	15
16		ELEV.RENOV.	1998		4,364	112	20	218	106	563	16
17		DRYWALL	1998		20,000	513	20	1,000	487	2,833	17
18		DRYWALL	1998		4,150	106	20	208	102	520	18
19		PAINT	1999		592	15	20	30	15	55	19
20		HEATER RENOV	1999		1,903	49	20	95	46	158	20
21		OXYGEN EXHAUST	1999		5,677	146	20	284	138	544	21
22		BOILER RENOV	1999		702	224	20	35	(189)	41	22
23		CEILING TILE	1999		703	18	20	35	17	50	23
24		DOOR/HINGES	1999		1,445	37	20	72	35	132	24
25		CARPET	1999		589	15	20	29	14	53	25
26		CUBICLE CURTAINS	1999		845	22	20	42	20	74	26
27		GENERATOR RENOV	1999		1,176	30	20	59	29	79	27
28		CEILING TILE	1999		703	18	20	35	17	50	28
29		PAVEMENT IMPROV	1999		3,980	102	20	199	97	299	29
30		TUCKPOINTING	1999		2,200	56	20	110	54	165	30
31		GENERATOR RENOV	1999		535	14	20	27	13	36	31
32		PAVEMENT IMPROV	1999		1,990	51	20	100	49	150	32
33		TV WIRING	1999		6,500	167	20	325	158	379	33
34		ELEVATOR RENOV	1999		3,301	85	20	165	80	206	34
35		LIFE SAFETY	1999		4,500	115	20	225	110	450	35
36		TOTAL (lines 4 thru 35)			\$ 85,165	\$ 2,390		\$ 4,259	\$ 1,869	\$ 9,166	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.

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		SPRINKLER SYSTEM		1999	3,240	83	20	162	79	311	9
10		COMPRESSOR		1999	1,209	31	20	60	29	100	10
11		CEILING TILE		1999	536	14	20	27	13	36	11
12		PHONE RENOV		1999	861	22	20	43	21	82	12
13		A/C RENOV		1999	573	15	20	29	14	44	13
14		SMOKE DAMPER		1999	789	20	20	39	19	75	14
15		TILE		1999	542	173	20	27	(146)	43	15
16		LANDSCAPING		1999	1,000	26	20	50	24	79	16
17		KEYSWITCH		1999	865	22	20	43	21	68	17
18		HEATER RENOV		1999	1,080	28	20	54	26	104	18
19		DOORS		1999	2,895	74	20	145	71	193	19
20		GENERATOR RENOV		1999	964	25	20	48	23	64	20
21		GENERATOR REPAIR		1999	545	14	20	27	13	29	21
22		MIXER RENOV		1999	824	21	20	41	20	79	22
23		BOILER RENOV		1999	741	19	20	37	18	59	23
24		TRANSMITTER		1999	732	19	20	37	18	40	24
25		REFRIG RENOV		1999	1,143	29	20	57	28	57	25
26		A/C RENOV		1999	1,351	432	20	68	(364)	108	26
27		WOOD DOORS		1999	2,350	60	20	118	58	167	27
28		WIRING		1999	945	24	20	47	23	67	28
29		COVE BASE		1999	2,156	55	20	108	53	171	29
30		WIRING		2000	1,225	14	20	31	17	31	30
31		TV WIRING		2000	7,384	181	20	369	188	369	31
32		PAINT		2000	2,956	60	20	123	63	123	32
33		REFRIG RENOV		2000	4,180	836	20	348	(488)	348	33
34		WALLPAPER		2000	22,360	406	20	839	433	839	34
35		CORNER GUARDS		2000	3,618	66	20	136	70	136	35
36		TOTAL (lines 4 thru 35)			\$ 67,064	\$ 2,769		\$ 3,113	\$ 344	\$ 3,822	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.

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		CORNERS GUARDS		2000	2,933	59	20	123	64	123	9
10		PAINT		2000	759	12	20	25	13	25	10
11		FYRE-SHIELD		2000	987	20	20	41	21	41	11
12		PAINT		2000	621	10	20	21	11	21	12
13		PAINT		2000	301	5	20	10	5	10	13
14		ELECTRICAL		2000	2,170	35	20	73	38	73	14
15		HANDRAILS		2000	3,911	782	20	261	(521)	261	15
16		COVE BASE		2000	854	171	20	57	(114)	57	16
17		SECO REFRIGERATION		2000	1,572	22	20	46	24	46	17
18		PAINT		2000	700	10	20	20	10	20	18
19		COVE BASE		2000	3,200	640	20	240	(400)	240	19
20		PAINT		2000	3,760	92	20	188	96	188	20
21		MIXING VALVE		2000	3,369	674	20	56	(618)	56	21
22		PAINT		2000	1,954	23	20	49	26	49	22
23		DOOR HOLDERS		2000	19,985	3,997	20	500	(3,497)	500	23
24		CUBICLES CURTAINS		2000	10,155	2,031	20	339	(1,692)	339	24
25		PAINT		2000	969	194	20	40	(154)	40	25
26		RADIATOR		2000	8,963	105	20	224	119	224	26
27		WIRING		2000	725	7	20	15	8	15	27
28		WIRING		2000	500	5	20	10	5	10	28
29		AWNING		2000	6,970	67	20	145	78	145	29
30		CAMERA SYSTEM		2000	2,274	17	20	38	21	38	30
31		MOTOR		2000	609	122	20	25	(97)	25	31
32		WALL GUARD		2000	1,840	368	20	77	(291)	77	32
33		HATCH SILL		2000	1,970	394	20	49	(345)	49	33
34		RADIATOR		2000	11,823	38	20	99	61	99	34
35		WINDOW TREATMENTS		2000	5,587	1,118	20	140	(978)	140	35
36		TOTAL (lines 4 thru 35)			\$ 99,461	\$ 11,018		\$ 2,911	\$ (8,107)	\$ 2,911	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.

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	HVAC		2000		525	105	20	13	(92)	13	9
10	BLOWER WHEELS		2000		1,045	209	20	18	(191)	18	10
11	BLOW OFF VALVE		2000		1,001	200	20	17	(183)	17	11
12	LIFT HANDLES		2000		1,503	18	20	38	20	38	12
13	REFRIG RENOV		2000		2,254	451	20	206	(245)	206	13
14	TRANSMITTER		2000		924	185	20	15	(170)	15	14
15	PAINT		2000		(111)	2	20	4	2	4	15
16	DRYWALL		2000		1,200	240	20	40	(200)	40	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 8,341	\$ 1,410		\$ 351	\$ (1,059)	\$ 351	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.

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 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.

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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											34
35											35
36	TOTAL (lines 4 thru 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.

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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											34
35											35
36	TOTAL (lines 4 thru 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.

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 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.

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			CCI Alloc	1996	\$ 46,984	\$ 1,205	35	\$ 1,342	\$ 137	\$ 5,482	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Allocation from Care Centers, Inc.		2000	57	1	20	2	1	2	9
10		Allocation from Care Centers, Inc.		1999	841	22	20	42	20	80	10
11		Allocation from Care Centers, Inc.		1998	347	9	20	17	8	46	11
12		Allocation from Care Centers, Inc.		1997	4,928	113	20	272	159	1,317	12
13		Allocation from Care Centers, Inc.		1996	5,417	71	20	261	190	895	13
14		Allocation from Care Centers, Inc.		1997	572	133	20	25	(108)	56	14
15		Allocation from Care Centers, Inc.		1994		16	20		(16)		15
16		Allocation from Care Centers, Inc.		1993		5	20		(5)		16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 59,146	\$ 1,575		\$ 1,961	\$ 386	\$ 7,878	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.

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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											34
35											35
36	TOTAL (lines 4 thru 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.

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	
37	Purchased in Prior Years	\$ 419,298	\$ 121,903	\$ 42,259	\$ (79,644)		\$ 143,291	37
38	Current Year Purchases	97,136	15,682	6,704	(8,978)		6,704	38
39	Fully Depreciated Assets	6,250					6,250	39
40								40
41	TOTALS	\$ 522,684	\$ 137,585	\$ 48,963	\$ (88,622)		\$ 156,245	41

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	
42	Allocation from Care Center			\$ 22,317	\$ 4,835	\$ 3,443	\$ (1,392)	10	\$ 7,726	42
43										43
44										44
45										45
46	TOTALS			\$ 22,317	\$ 4,835	\$ 3,443	\$ (1,392)		\$ 7,726	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 1,360,153	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 175,124	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 89,672	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (85,452)	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 305,457	51

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* 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.

SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.
0040444
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
Sheridan Shores	379,452	65,868	37,951	(27,917)	124,819
Care Centers, Inc.	39,846	5,155	4,308	(847)	18,472
Ventlease LLC		50,880		(50,880)	
TOTALS	419,298	121,903	42,259	(79,644)	143,291

LINE 29: CURRENT YEAR

Sheridan Shores	94,891	15,296	6,652	(8,644)	6,652
Care Centers, Inc.	2,245	386	52	(334)	52
Ventlease LLC					
TOTALS	97,136	15,682	6,704	(8,978)	6,704

LINE 30: FULLY DEPRECIATED

Sheridan Shores	6,250				6,250
Care Centers, Inc.					
Ventlease LLC					
TOTALS	6,250				6,250

TOTALS (Should Tie to Totals on Page 13)

Sheridan Shores	480,593	81,164	44,603	(36,561)	137,721
Care Centers, Inc.	42,091	5,541	4,360	(1,181)	18,524
Ventlease LLC		50,880		(50,880)	
TOTALS	522,684	137,585	48,963	(88,622)	156,245

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Sam and David Gorenstein

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>Edgewater LLC</u>	<u>188</u>	<u>5/1/93</u>	<u>\$ 994,994</u>			<u>3</u>
4	Additions							<u>4</u>
5	Less: Rental Income				<u>(6,347)</u>			<u>5</u>
6	Care Center Allocation				<u>4,425</u>			<u>6</u>
7	TOTAL		188		\$ 993,072			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending	Annual Rent
--------------------	-------------

12.	<u>/2001</u>	\$ _____
13.	<u>/2002</u>	\$ _____
14.	<u>/2003</u>	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 7,339 Description: see attached

(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		\$ _____	\$ 0	21

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

	Facility			
	1	2	3	4
	Drop-outs	Completed	Contract	Total
1 Community College Tuition	\$	\$ 885	\$	\$ 885
2 Books and Supplies				
3 Classroom Wages (a)				
4 Clinical Wages (b)				
5 In-House Trainer Wages (c)				
6 Transportation				
7 Contractual Payments				
8 Nurse Aide Competency Tests				
9 TOTALS	\$	\$ 885	\$	\$ 885
10 SUM OF line 9, col. 1 and 2 (e)	\$ 885			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	3

- (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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

Facility Name & ID Number

SHERIDAN SHORES CARE & REHABILITATION CENTER, INC. # 0040444

Report Period Beginning:

01/01/00

Ending:

12/31/00

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 12,206	\$		\$ 12,206	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			2,470			2,470	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			14,683			14,683	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				75,819		75,819	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-1		175,870					175,870	12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**	39-2					176,310		176,310	13
14	TOTAL			\$ 175,870		\$ 29,359	\$ 252,129		\$ 457,358	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 nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

<u>Special Services - Supplies (Column 6 - Other)</u>	<u>Amount</u>
1 Medical Supplies	21,134
2 Air-Fluidized Beds	34,673
3 Oxygen	10,383
4 Equipment Rental	543
5 Respiratory Supplies	54,835
6 Radiology	1,033
7 Enteral Supplies	7,388
8 Lab	1,100
9 Vent Equipment Rental	45,221
10	
	<u>176,310</u>

<u>Outside Therapies (Column 5 - Other)</u>	<u>Amount</u>
1 Respiratory Therapy	
2	
3	
4	
5	
6	
7	
8	
9	
10	
	<u> </u>
	<u> </u>

Facility Name & ID Number SHERIDAN SHORES CARE & REHABILITATION CEN # 0040444 Report Period Beginning: 01/01/00 Ending: 12/31/00
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1	Cash on Hand and in Banks	\$ 72,626	\$ 72,638 1
2	Cash-Patient Deposits	88,293	88,293 2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,232,147	1,232,147 3
4	Supply Inventory (priced at)		4
5	Short-Term Investments		5
6	Prepaid Insurance	86,666	86,666 6
7	Other Prepaid Expenses	1,140	1,140 7
8	Accounts Receivable (owners or related parties)		(471,851) 8
9	Other(specify): See supplemental schedule	307,271	337,633 9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,788,143	\$ 1,346,667 10
B. Long-Term Assets			
11	Long-Term Notes Receivable		11
12	Long-Term Investments		12
13	Land		13
14	Buildings, at Historical Cost		14
15	Leasehold Improvements, at Historical Cos	692,810	692,810 15
16	Equipment, at Historical Cost	557,797	557,797 16
17	Accumulated Depreciation (book methods)	(359,125)	(359,125) 17
18	Deferred Charges		18
19	Organization & Pre-Operating Costs	23,948	106,903 19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(23,948)	(23,948) 20
21	Restricted Funds		21
22	Other Long-Term Assets (specify):	453,953	453,953 22
23	Other(specify): See supplemental schedule		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,345,435	\$ 1,428,390 24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,133,578	\$ 2,775,057 25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 236,155	\$ 236,155 26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits	88,185	88,185 28
29	Short-Term Notes Payable	2,389,057	2,389,057 29
30	Accrued Salaries Payable	265,537	265,537 30
31	Accrued Taxes Payable (excluding real estate taxes)	21,400	21,400 31
32	Accrued Real Estate Taxes(Sch.IX-B)	299,008	299,008 32
33	Accrued Interest Payable	108,729	108,729 33
34	Deferred Compensation	3,044	3,044 34
35	Federal and State Income Taxes		35
Other Current Liabilities(specify):			
36	See supplemental schedule	32,403	32,403 36
37			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,443,518	\$ 3,443,518 38
D. Long-Term Liabilities			
39	Long-Term Notes Payable	585,000	585,000 39
40	Mortgage Payable		40
41	Bonds Payable		41
42	Deferred Compensation		42
Other Long-Term Liabilities(specify):			
43	See supplemental schedule		43
44			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 585,000	\$ 585,000 45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,028,518	\$ 4,028,518 46
47	TOTAL EQUITY(page 18, line 24)	\$ (894,940)	\$ #REF! 47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,133,578	\$ #REF! 48

*(See instructions.)

OTHER CURRENT ASSETS:	<u>Amount</u>	<u>Amount</u>
Real Estate Tax Escrow	264,345	264,345
Deferred Replacement Tax	22,275	22,275
Stock Subscription Receivable		1,880
Option Deposit		28,482
Deferred Rent	20,651	20,651
	<u>307,271</u>	<u>337,633</u>

OTHER CURRENT LIABILITIES:	<u>Amount</u>	<u>Amount</u>
Due on Equipment	32,403	32,403
	<u>32,403</u>	<u>32,403</u>

OTHER NON CURRENT ASSETS:

Construction In Progress
 Utility Deposit
 Loan Costs

	<u> </u>	<u> </u>
	<u> </u>	<u> </u>

OTHER NON CURRENT LIABILITIES:

	<u> </u>	<u> </u>
	<u> </u>	<u> </u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (429,678)	1
2	Restatements (describe):		2
3	<u>Schedule attached</u>	(6,669)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (436,347)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(458,593)	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)	\$ (458,593)	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)	\$ (894,940)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number SHERIDAN SHORES CARE & REHA# 0040444 Report Period Beginning: 01/01/00 Ending: 12/31/00

Balance per General Ledger (436,347)

Adjustments:

-

-

To record a late 1999 journal entry that was not included on the
prior year cost report. RE: to record depreciation and accumulated depr.

6,669

Total adjustments

6,669

Balance - Beginning of Year

(429,678)

Equity(Deficit) from Page 17 Col 1

(894,940)

Related Party

Equity(Deficit)

-348762

Income

-9759

(358,521)

Combined Equity - End of Year

(1,253,461)

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	\$ 5,967,725	1
2	Discounts and Allowances for all Levels	(431,854)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,535,871	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	130,687	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 130,687	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide 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	6,347	16
17	Sale of Drugs	71,661	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,088	19
20	Radiology and X-Ray	1,472	20
21	Other Medical Services	1,144,381	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,233,949	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	98	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 98	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	6,324	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,324	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,906,929	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	1,165,331	31
32	Health Care	2,635,460	32
33	General Administration	1,413,222	33
B. Capital Expense			
34	Ownership	1,590,941	34
C. Ancillary Expense			
35	Special Cost Centers	457,356	35
36	Provider Participation Fee	103,212	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,365,522	40
41	Income before Income Taxes (line 30 minus line 40)**	(458,593)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (458,593)	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.

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

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

<u>DESCRIPTION</u>	<u>AMOUNT</u>
1 Replacement Tax Credit	6,200
2 Miscellaneous Income (adjusted out on page 5)	15
3 Jury Duty Income (adjusted out on page 5)	60
4 Misc. Private Revenue	49
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
TOTALS	<u><u>6,324</u></u>

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	2,048	2,265	\$ 52,415	\$ 23.14	1
2	Assistant Director of Nursing	2,112	2,459	49,911	20.30	2
3	Registered Nurses	44,062	45,548	880,367	19.33	3
4	Licensed Practical Nurses	13,439	19,281	336,604	17.46	4
5	Nurse Aides & Orderlies	90,497	98,281	796,504	8.10	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	9,053	10,391	175,870	16.93	7
8	Rehab/Therapy Aides	6,597	7,443	79,581	10.69	8
9	Activity Director	1,944	2,205	32,330	14.66	9
10	Activity Assistants	12,277	12,879	90,374	7.02	10
11	Social Service Workers	5,123	5,504	72,094	13.10	11
12	Dietician	1,239	1,334	17,490	13.11	12
13	Food Service Supervisor	1,736	1,992	25,067	12.58	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,218	22,954	157,735	6.87	15
16	Dishwashers					16
17	Maintenance Workers	3,906	4,423	49,932	11.29	17
18	Housekeepers	20,549	21,968	135,661	6.18	18
19	Laundry	7,529	8,102	54,376	6.71	19
20	Administrator					20
21	Assistant Administrator	480	486	7,275	14.97	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,651	9,395	95,909	10.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,027	2,387	30,069	12.60	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	254,487	279,297	\$ 3,139,564 *	\$ 11.24	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	443	\$ 17,722	1-3	35
36	Medical Director	monthly	9,950	9-3	36
37	Medical Records Consultant	monthly	4,032	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	3,440	10-3	39
40	Physical Therapy Consultant	79	3,925	10A-3	40
41	Occupational Therapy Consultant	56	2,775	10A-3	41
42	Respiratory Therapy Consultant		1,157	10A-3	42
43	Speech Therapy Consultant	18	900	10A-3	43
44	Activity Consultant	44	2,032	11-3	44
45	Social Service Consultant	monthly	3,429	12-3	45
46	Other(specify)				46
47					47
48	CCI salaries	see attached	28,977		48
49	TOTAL (lines 35 - 48)	640	\$ 78,339		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	209	\$ 9,930	10-3	50
51	Licensed Practical Nurses	869	14,227	10-3	51
52	Nurse Aides	221	5,433	10-3	52
53	TOTAL (lines 50 - 52)	1,299	\$ 29,590		53

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

<u># of Hrs. Actually Worked</u>	<u># of Hrs. Paid and Accrued</u>	<u>Reporting Period Total Salaries, Wages</u>	<u>Average Hourly Wage</u>
		\$	\$
<u>0</u>	<u>0</u>	\$ <u>0</u>	\$ <u>#DIV/0!</u>

Facility Name & ID Number SHERIDAN SHORES CARE & REHABILITATION CENTER, INC. # 0040444 Report Period Beginning: 01/01/00 Ending: 12/31/00

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. Illinois Council of Long Term Care \$5655
- (3) Did the nursing home make political contributions or payments to a political 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? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,282 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? YES _____ NO X
- (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

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 103,212
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 of Public Aid, 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 benefit on Schedule V. \$ 26,645 Has any meal income been offset against related costs? NA Indicate the amount. \$ _____
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? NONE
d. Have vehicle usage logs been maintained? NA
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NA
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? NA
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (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 \$2500, 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.

Date: 07/17/2000

To: Administrator/Cost Report Preparer

From: Office of Health Finance

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to be entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 1, do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 1/2 by 14 size white paper with an 8 1/2 by 14 image on the paper. To ensure an 8 1/2 by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 1/2 by 11. We cannot accept a report with an 8 1/2 by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu bar after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use File-Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been sealed you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can go to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/ov