

		FOR BHF USE					

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**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

**I. IDPH License ID Number:** 0040444

**Facility Name:** Sheridan Shores Care & Rehab Ctr

**Address:** 5838 North Sheridan Road Chicago 60660  
 Number City Zip Code

**County:** Cook

**Telephone Number:** (773) 769-2230 Fax # (773) 769-3579

**HFS ID Number:** 363873049001

**Date of Initial License for Current Owners:** 6/4/1993

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** Steve Lavenda **Telephone Number:** (847) 236 - 1111

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/07 to 12/31/07 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____
	(Type or Print Name) _____ (Date) _____
	(Title) _____
Paid Preparer	(Signed) _____ (Date) _____
	(Print Name and Title) <u>Edward N. Slack, C.P.A.</u>
	(Firm Name & Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>

MAIL TO: BUREAU OF HEALTH FINANCE  
 ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES  
 201 S. Grand Avenue East  
 Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444 Report Period Beginning: 01/01/07 Ending: 12/31/07

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>63</u>	Skilled (SNF)	<u>63</u>	<u>22,995</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>128</u>	Intermediate (ICF)	<u>128</u>	<u>46,720</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>191</u>	TOTALS	<u>191</u>	<u>69,715</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	<u>62,452</u>	<u>1,113</u>	<u>2,194</u>	<u>65,759</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>62,452</u>	<u>1,113</u>	<u>2,194</u>	<u>65,759</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.33%

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

1,538 (Do not include bed-hold days in Section B.)

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

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

None

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

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

YES  NO

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

YES  NO

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

Date started 05/01/93

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

YES  Date 05/01/93 NO

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

YES  NO  If YES, enter number of beds certified 63 and days of care provided 2,194

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/07 Ending: 12/31/07

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	237,185	34,239	10,709	282,133		282,133	1,820	283,953			1
2	Food Purchase		261,074		261,074		261,074	296	261,370			2
3	Housekeeping	180,826	39,675		220,501		220,501	(2,469)	218,032			3
4	Laundry	76,100	20,183		96,283		96,283	(228)	96,055			4
5	Heat and Other Utilities			212,229	212,229		212,229	2,775	215,004			5
6	Maintenance	193,737	(167)	130,001	323,571		323,571	9,426	332,997			6
7	Other (specify):*							1,279	1,279			7
8	<b>TOTAL General Services</b>	<b>687,848</b>	<b>355,004</b>	<b>352,939</b>	<b>1,395,791</b>		<b>1,395,791</b>	<b>12,899</b>	<b>1,408,690</b>			<b>8</b>
	<b>B. Health Care and Programs</b>											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	2,005,372	36,395	7,652	2,049,419		2,049,419	26,871	2,076,290			10
10a	Therapy	155,271		756	156,027		156,027	2,938	158,965			10a
11	Activities	95,117	15,130		110,247		110,247		110,247			11
12	Social Services	248,169	4,010	13,894	266,073		266,073	8,449	274,522			12
13	CNA Training											13
14	Program Transportation			50	50		50		50			14
15	Other (specify):*							5,399	5,399			15
16	<b>TOTAL Health Care and Programs</b>	<b>2,503,929</b>	<b>55,535</b>	<b>25,952</b>	<b>2,585,416</b>		<b>2,585,416</b>	<b>43,657</b>	<b>2,629,073</b>			<b>16</b>
	<b>C. General Administration</b>											
17	Administrative	103,853		60,000	163,853		163,853	66,573	230,426			17
18	Directors Fees											18
19	Professional Services			161,831	161,831	(12,000)	149,831	(57,922)	91,909			19
20	Dues, Fees, Subscriptions & Promotions			44,139	44,139		44,139	(9,664)	34,475			20
21	Clerical & General Office Expenses	123,909	40,465	354,092	518,466		518,466	(139,241)	379,225			21
22	Employee Benefits & Payroll Taxes			561,329	561,329		561,329	(4,955)	556,374			22
23	Inservice Training & Education			3,408	3,408		3,408		3,408			23
24	Travel and Seminar			7,345	7,345		7,345	1,230	8,575			24
25	Other Admin. Staff Transportation			2,787	2,787		2,787	1,638	4,425			25
26	Insurance-Prop.Liab.Malpractice			174,289	174,289		174,289	1,751	176,040			26
27	Other (specify):*							34,945	34,945			27
28	<b>TOTAL General Administration</b>	<b>227,762</b>	<b>40,465</b>	<b>1,369,220</b>	<b>1,637,447</b>	<b>(12,000)</b>	<b>1,625,447</b>	<b>(105,645)</b>	<b>1,519,802</b>			<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,419,539</b>	<b>451,004</b>	<b>1,748,111</b>	<b>5,618,654</b>	<b>(12,000)</b>	<b>5,606,654</b>	<b>(49,089)</b>	<b>5,557,565</b>			<b>29</b>

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr #0040444 Report Period Beginning: 01/01/07 Ending: 12/31/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			166,792	166,792		166,792	202,916	369,708		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			163,315	163,315		163,315	745,575	908,890		32
33	Real Estate Taxes			170,279	170,279	12,000	182,279	3,169	185,448		33
34	Rent-Facility & Grounds			1,104,782	1,104,782		1,104,782	(1,101,440)	3,342		34
35	Rent-Equipment & Vehicles			1,849	1,849		1,849	464	2,313		35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			1,607,017	1,607,017	12,000	1,619,017	(149,316)	1,469,701		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		134,355	125,462	259,817		259,817	(4,720)	255,097		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			104,573	104,573		104,573		104,573		42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>		134,355	230,035	364,390		364,390	(4,720)	359,670		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,419,539	585,359	3,585,163	7,590,061		7,590,061	(203,126)	7,386,935		45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning: 01/01/07

Ending: 12/31/07

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(61,969)	30		9
10	Interest and Other Investment Income	(1)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(44)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(534)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(233,827)	21		24
25	Fund Raising, Advertising and Promotional	(14,304)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(171,349)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (482,028)		\$	30

BHF 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)	278,902		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 278,902		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (203,126)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		
	Amount	Reference
1	Rental Income	06
2	Patent Clothing	19
3	Amortizations- Building Co.	30
4	Collection Expense	21
5	COPY Dues	20
6	Annual Report Fees	20
7	2008 Seminar Expense	24
8	2008 Seminar Expense	24
9	2008 Legal Fees	19
10	Reling Fees- Building Co.	20
11	Non-Allowable Professional Fees	19
12	Non-Allowable Interest	33
13	Non-Allowable Expense	21
14	Other Income	21
15		15
16		16
17		17
18		18
19		19
20		20
21		21
22		22
23		23
24		24
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90		90
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92		92
93		93
94		94
95		95
96		96
97		97
98		98
99		99
100		100
101	Total	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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)	
	<b>A. General Services</b>													
1	Dietary			276	3,912	(2,347)		(21)					1,820	1
2	Food Purchase	(44)		340									296	2
3	Housekeeping			518	52	6		(3,045)					(2,469)	3
4	Laundry							(228)					(228)	4
5	Heat and Other Utilities			2,470	134	171							2,775	5
6	Maintenance	(1,650)		11,638	17	70		(649)					9,426	6
7	Other (specify):*			908	371								1,279	7
8	<b>TOTAL General Services</b>	<b>(1,694)</b>		<b>16,150</b>	<b>4,486</b>	<b>(2,100)</b>		<b>(3,943)</b>					<b>12,899</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(1,014)			30,389	(541)		(1,963)					26,871	10
10a	Therapy				2,938								2,938	10a
11	Activities													11
12	Social Services				8,449								8,449	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				5,399								5,399	15
16	<b>TOTAL Health Care and Programs</b>	<b>(1,014)</b>			<b>47,175</b>	<b>(541)</b>		<b>(1,963)</b>					<b>43,657</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			11,786	53,381	1,406							66,573	17
18	Directors Fees													18
19	Professional Services	(3,090)		(57,078)	2,227	19							(57,922)	19
20	Fees, Subscriptions & Promotions	(17,171)	250	7,118	33	106							(9,664)	20
21	Clerical & General Office Expenses	(325,749)		173,505	13,818	2,355	(3,170)						(139,241)	21
22	Employee Benefits & Payroll Taxes			(297)	(22)			(4,636)					(4,955)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(585)		1,204	641			(30)					1,230	24
25	Other Admin. Staff Transportation			1,558		80							1,638	25
26	Insurance-Prop.Liab.Malpractice			1,579	17	155							1,751	26
27	Other (specify):*			25,310	9,074	561							34,945	27
28	<b>TOTAL General Administration</b>	<b>(346,595)</b>	<b>250</b>	<b>164,685</b>	<b>79,169</b>	<b>4,682</b>	<b>(3,170)</b>	<b>(4,666)</b>					<b>(105,645)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(349,303)</b>	<b>250</b>	<b>180,835</b>	<b>130,830</b>	<b>2,041</b>	<b>(3,170)</b>	<b>(10,572)</b>					<b>(49,089)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(61,969)	242,986	20,136	846	121	796						202,916	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(8,103)	710,745	37,994	3,642	202	1,095						745,575	32
33	Real Estate Taxes			2,947	199	23							3,169	33
34	Rent-Facility & Grounds		(1,104,782)	3,183		159							(1,101,440)	34
35	Rent-Equipment & Vehicles			419	6	39							464	35
36	Other (specify):*	(62,653)	62,653											36
37	<b>TOTAL Ownership</b>	<b>(132,725)</b>	<b>(88,398)</b>	<b>64,679</b>	<b>4,693</b>	<b>544</b>	<b>1,891</b>						<b>(149,316)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(3,140)		(1,580)					(4,720)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>					<b>(3,140)</b>		<b>(1,580)</b>					<b>(4,720)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(482,028)</b>	<b>(88,148)</b>	<b>245,514</b>	<b>135,523</b>	<b>(555)</b>	<b>(1,279)</b>	<b>(12,153)</b>					<b>(203,126)</b>	<b>45</b>

**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		
				Sheridan Shores Property LLC		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 1,104,782	Sheridan Shores Property LLC	100.00%	\$	\$ (1,104,782)	1
2	V	20 Filing Fees		Sheridan Shores Property LLC	100.00%	250	250	2
3	V	30 Depreciation Expense		Sheridan Shores Property LLC	100.00%	242,986	242,986	3
4	V	36 Amortization Expense		Sheridan Shores Property LLC	100.00%	62,653	62,653	4
5	V	32 Interest Expense		Sheridan Shores Property LLC	100.00%	710,745	710,745	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		\$ 1,104,782			\$ 1,016,634	\$ * (88,148)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/07 Ending: 12/31/07

## 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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 Dietary		Care Centers, Inc.	100.00%	\$ 276	\$ 276	15
16	V	02 Food		Care Centers, Inc.	100.00%	340	340	16
17	V	03 Housekeeping		Care Centers, Inc.	100.00%	518	518	17
18	V	05 Utilities		Care Centers, Inc.	100.00%	2,470	2,470	18
19	V	06 Maintenance		Care Centers, Inc.	100.00%	4,073	4,073	19
20	V	17 Administrative		Care Centers, Inc.	100.00%	2,467	2,467	20
21	V	19 Professional Fees	70,100	Care Centers, Inc.	100.00%	13,022	(57,078)	21
22	V	20 Dues and Subscriptions		Care Centers, Inc.	100.00%	7,118	7,118	22
23	V	21 Office and Clerical		Care Centers, Inc.	100.00%	20,628	20,628	23
24	V	24 Seminar and Travel		Care Centers, Inc.	100.00%	1,204	1,204	24
25	V	25 Other Staff Admin. Trans.		Care Centers, Inc.	100.00%	1,558	1,558	25
26	V	26 Insurance		Care Centers, Inc.	100.00%	1,579	1,579	26
27	V	30 Depreciation		Care Centers, Inc.	100.00%	20,136	20,136	27
28	V	32 Interest		Care Centers, Inc.	100.00%	37,994	37,994	28
29	V	33 Real Estate Taxes		Care Centers, Inc.	100.00%	2,947	2,947	29
30	V	34 Rent - Building		Care Centers, Inc.	100.00%	3,183	3,183	30
31	V	35 Rent - Equipment & Auto		Care Centers, Inc.	100.00%	419	419	31
32	V	06 Maintenance		Care Centers, Inc.	100.00%	7,565	7,565	32
33	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	908	908	33
34	V	17 Administrative		Care Centers, Inc.	100.00%	9,319	9,319	34
35	V	21 Office and Clerical	1,981	Care Centers, Inc.	100.00%	154,858	152,877	35
36	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	25,310	25,310	36
37	V	22 Employee Benefits	297	Care Centers, Inc.	100.00%		(297)	37
38	V							38
39	Total		\$ 72,378			\$ 317,892	\$ * 245,514	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/07 Ending: 12/31/07

## VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	03	Housekeeping	\$	Care Centers Clinical, Inc.	100.00%	\$ 52	\$ 52	15	
16	V	05	Utilities		Care Centers Clinical, Inc.	100.00%	134	134	16	
17	V	06	Maintenance		Care Centers Clinical, Inc.	100.00%	17	17	17	
18	V	19	Professional Fees		Care Centers Clinical, Inc.	100.00%	2,227	2,227	18	
19	V	20	Dues and Subscriptions		Care Centers Clinical, Inc.	100.00%	33	33	19	
20	V	21	Office & Clerical		Care Centers Clinical, Inc.	100.00%	130	130	20	
21	V	24	Travel and Seminar		Care Centers Clinical, Inc.	100.00%	641	641	21	
22	V	26	Insurance		Care Centers Clinical, Inc.	100.00%	17	17	22	
23	V	30	Depreciation		Care Centers Clinical, Inc.	100.00%	846	846	23	
24	V	32	Interest		Care Centers Clinical, Inc.	100.00%	3,642	3,642	24	
25	V	33	Real Estate Taxes		Care Centers Clinical, Inc.	100.00%	199	199	25	
26	V	35	Rent - Equipment & Auto		Care Centers Clinical, Inc.	100.00%	6	6	26	
27	V	01	Dietary Salary		Care Centers Clinical, Inc.	100.00%	3,912	3,912	27	
28	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc.	100.00%	371	371	28	
29	V	10	Nursing Salary		Care Centers Clinical, Inc.	100.00%	30,389	30,389	29	
30	V	10a	Rehab Salary		Care Centers Clinical, Inc.	100.00%	2,938	2,938	30	
31	V	12	Social Service Salary	144	Care Centers Clinical, Inc.	100.00%	8,593	8,449	31	
32	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc.	100.00%	5,399	5,399	32	
33	V	17	Administration Salary		Care Centers Clinical, Inc.	100.00%	53,381	53,381	33	
34	V	21	Office Salary		Care Centers Clinical, Inc.	100.00%	13,688	13,688	34	
35	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc.	100.00%	9,074	9,074	35	
36	V	22	Employee Benefits	22	Care Centers Clinical, Inc.	100.00%		(22)	36	
37	V								37	
38	V								38	
39	Total			\$ 166			\$ 135,689	\$ * 135,523	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/07 Ending: 12/31/07

## VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	01	Dietary	\$	Care Centers Health Systems, Inc.	100.00%	\$ 856	\$ 856	15	
16	V	03	Housekeeping		Care Centers Health Systems, Inc.	100.00%	6	6	16	
17	V	05	Heat and Other Utilities		Care Centers Health Systems, Inc.	100.00%	171	171	17	
18	V	06	Maintenance		Care Centers Health Systems, Inc.	100.00%	70	70	18	
19	V	19	Professional Fees		Care Centers Health Systems, Inc.	100.00%	19	19	19	
20	V	20	Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	106	106	20	
21	V	21	Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	367	367	21	
22	V	25	Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	80	80	22	
23	V	26	Insurance		Care Centers Health Systems, Inc.	100.00%	155	155	23	
24	V	30	Depreciation		Care Centers Health Systems, Inc.	100.00%	121	121	24	
25	V	32	Interest		Care Centers Health Systems, Inc.	100.00%	202	202	25	
26	V	33	Real Estate Taxes		Care Centers Health Systems, Inc.	100.00%	23	23	26	
27	V	34	Rent - Building		Care Centers Health Systems, Inc.	100.00%	159	159	27	
28	V	35	Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	39	39	28	
29	V	01	Dietary	4,769	Care Centers Health Systems, Inc.	100.00%	1,566	(3,203)	29	
30	V	02	Food		Care Centers Health Systems, Inc.	100.00%			30	
31	V	03	Housekeeping		Care Centers Health Systems, Inc.	100.00%			31	
32	V	10	Nursing	805	Care Centers Health Systems, Inc.	100.00%	264	(541)	32	
33	V	21	Clerical and General Office		Care Centers Health Systems, Inc.	100.00%			33	
34	V	25	Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%			34	
35	V	39	Ancillary	4,674	Care Centers Health Systems, Inc.	100.00%	1,534	(3,140)	35	
36	V	17	Administrative		Care Centers Health Systems, Inc.	100.00%	1,406	1,406	36	
37	V	21	Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	1,988	1,988	37	
38	V	27	Employee Benefits		Care Centers Health Systems, Inc.	100.00%	561	561	38	
39	Total			\$ 10,248			\$ 9,693	\$ *	(555)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Repairs	\$	Vent Lease, LLC.	100.00%	\$	\$	15
16	V	21	Office and Clerical		Vent Lease, LLC.	100.00%			16
17	V	30	Depreciation		Vent Lease, LLC.	100.00%			17
18	V	32	Interest		Vent Lease, LLC.	100.00%			18
19	V	30	Depreciation		Vent Lease, LLC.	100.00%	796	796	19
20	V	32	Interest		Vent Lease, LLC.	100.00%	1,095	1,095	20
21	V	21	Office and Clerical	3,170	Vent Lease, LLC.	100.00%		(3,170)	21
22	V	39	Ancillary		Vent Lease, LLC.	100.00%			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			\$ 3,170			\$ 1,891	\$ * (1,279)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/07 Ending: 12/31/07

## 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	\$ 264	Xcel Supply, LLC	100.00%	\$ 243	\$ (21)	15
16	V	3 Housekeeping	37,758	Xcel Supply, LLC	100.00%	34,713	(3,045)	16
17	V	4 Laundry	2,829	Xcel Supply, LLC	100.00%	2,601	(228)	17
18	V	6 Repairs & Maintenance	8,044	Xcel Supply, LLC	100.00%	7,395	(649)	18
19	V	10 Nursing	24,341	Xcel Supply, LLC	100.00%	22,378	(1,963)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service		Xcel Supply, LLC	100.00%			21
22	V	20 Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits	8,062	Xcel Supply, LLC	100.00%	3,426	(4,636)	24
25	V	24 Seminars & Education	373	Xcel Supply, LLC	100.00%	343	(30)	25
26	V	39 Ancillary	19,593	Xcel Supply, LLC	100.00%	18,013	(1,580)	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		\$ 101,264			\$ 89,112	\$ * (12,153)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	\$	CCS Employee Benefit Group	100.00%	\$ 66,105	\$ 66,105	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	66,105	CCS Employee Benefit Group	100.00%		(66,105)	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			\$ 66,105			\$ 66,105	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/07 Ending: 12/31/07

## 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	45.75%	See Attached	1.35	2.93%	Alloc. Salary	\$	17-7	1
2	Adam Vales	Relative	Clerical	N/A	See Attached	0.41	1.03%	Alloc. Salary	569	22-7	2
3	Mark Steinberg	Relative	Administrative	N/A	See Attached	2.22	4.04%	Alloc. Salary	5,899	17-7	3
4	Kim Rudolph	Relative	Clerical	N/A	See Attached	0.36	1.03%	Alloc. Salary	313	22-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 6,781		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning:

01/01/07

Ending: 12/31/07

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,625,640	33	\$ 6,823	\$ 65,755	\$ 276	1
2	02	Food	Patient Days	1,625,640	33	8,403	65,755	340	2
3	03	Housekeeping	Patient Days	1,625,640	33	12,807	65,755	518	3
4	05	Utilities	Patient Days	1,625,640	33	61,054	65,755	2,470	4
5	06	Maintenance	Patient Days	1,625,640	33	100,693	65,755	4,073	5
6	17	Administrative	Patient Days	1,625,640	33	61,000	65,755	2,467	6
7	19	Professional Fees	Patient Days	1,625,640	33	321,947	65,755	13,022	7
8	20	Dues and Subscriptions	Patient Days	1,625,640	33	175,974	65,755	7,118	8
9	21	Office and Clerical	Patient Days	1,625,640	33	509,990	65,755	20,628	9
10	24	Seminar and Travel	Patient Days	1,625,640	33	29,773	65,755	1,204	10
11	25	Other Staff Admin. Trans.	Patient Days	1,625,640	33	38,529	65,755	1,558	11
12	26	Insurance	Patient Days	1,625,640	33	39,041	65,755	1,579	12
13	30	Depreciation	Patient Days	1,625,640	33	497,823	65,755	20,136	13
14	32	Interest	Patient Days	1,625,640	33	939,326	65,755	37,994	14
15	33	Real Estate Taxes	Patient Days	1,625,640	33	72,865	65,755	2,947	15
16	34	Rent - Building	Patient Days	1,625,640	33	78,695	65,755	3,183	16
17	35	Rent - Equipment & Auto	Patient Days	1,625,640	33	10,366	65,755	419	17
18	06	Maintenance	Patient Days	1,625,640	33	187,019	187,019	7,565	18
19	06	Maintenance	Direct Allocation			456,812	456,812		19
20	07	Emp. Ben. - Gen. Serv.	Patient Days	1,625,640	33	91,856	65,755	908	20
21	17	Administrative	Patient Days	1,625,640	33	230,402	230,402	9,319	21
22	21	Office and Clerical	Patient Days	1,625,640	33	3,779,534	3,779,534	152,877	22
23	21	Office and Clerical	Direct Allocation			489,346	489,346	1,981	23
24	27	Emp. Ben. - Gen. Admin.	Patient Days	1,625,640	33	691,109	65,755	25,310	24
25	TOTALS					\$ 8,891,187	\$ 5,143,115	\$ 317,892	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr# 0040444

Report Period Beginning:

01/01/07Ending: 12/31/07

## VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	03	Housekeeping	Patient Days	1,625,640	32	\$ 1,294	\$ 65,755	\$ 52	1	
2	05	Utilities	Patient Days	1,625,640	32	3,307	65,755	134	2	
3	06	Maintenance	Patient Days	1,625,640	32	410	65,755	17	3	
4	19	Professional Fees	Patient Days	1,625,640	32	55,053	65,755	2,227	4	
5	20	Dues and Subscriptions	Patient Days	1,625,640	32	809	65,755	33	5	
6	21	Office & Clerical	Patient Days	1,625,640	32	3,220	65,755	130	6	
7	24	Travel and Seminar	Patient Days	1,625,640	32	15,843	65,755	641	7	
8	26	Insurance	Patient Days	1,625,640	32	409	65,755	17	8	
9	30	Depreciation	Patient Days	1,625,640	32	20,909	65,755	846	9	
10	32	Interest	Patient Days	1,625,640	32	90,038	65,755	3,642	10	
11	33	Real Estate Taxes	Patient Days	1,625,640	32	4,921	65,755	199	11	
12	35	Rent - Equipment & Auto	Patient Days	1,625,640	32	155	65,755	6	12	
13	01	Dietary Salary	Patient Days	1,625,640	32	96,717	96,717	65,755	3,912	13
14	07	Emp. Ben. - Gen. Serv.	Patient Days	1,625,640	32	9,180	65,755	371	14	
15	10	Nursing Salary	Patient Days	1,625,640	32	751,308	751,308	65,755	30,389	15
16	10a	Rehab Salary	Patient Days	1,625,640	32	72,628	72,628	65,755	2,938	16
17	12	Social Service Salary	Patient Days	1,625,640	32	208,543	208,543	65,755	8,435	17
18	15	Emp. Ben. - Healthcare	Patient Days	1,625,640	32	133,126	65,755	5,385	18	
19	17	Administration Salary	Patient Days	1,625,640	32	1,319,729	1,319,729	65,755	53,381	19
20	21	Office Salary	Patient Days	1,625,640	32	338,399	338,399	65,755	13,688	20
21	27	Emp. Ben. - Gen. Admin.	Patient Days	1,625,640	32	224,344	65,755	9,074	21	
22	10	Nursing Salary	Direct Allocation			13,379	13,379		22	
23	12	Social Service Salary	Direct Allocation			8,845	8,845		158	23
24	15	Emp. Ben. - Healthcare	Direct Allocation			1,994			14	24
25	TOTALS					\$ 3,374,561	\$ 2,809,547	\$ 135,689	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning:

01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	01	Dietary	Gross Billable Income	4,431,674	33	94,358	40,183	856	1	
2	03	Housekeeping	Gross Billable Income	4,431,674	33	663	40,183	6	2	
3	05	Heat and Other Utilities	Gross Billable Income	4,431,674	33	18,909	40,183	171	3	
4	06	Maintenance	Gross Billable Income	4,431,674	33	7,696	40,183	70	4	
5	19	Professional Fees	Gross Billable Income	4,431,674	33	2,050	40,183	19	5	
6	20	Dues, Fees, Subscriptions	Gross Billable Income	4,431,674	33	11,727	40,183	106	6	
7	21	Clerical and General Office	Gross Billable Income	4,431,674	33	40,502	40,183	367	7	
8	25	Other Admin. Staff Transport.	Gross Billable Income	4,431,674	33	8,860	40,183	80	8	
9	26	Insurance	Gross Billable Income	4,431,674	33	17,050	40,183	155	9	
10	30	Depreciation	Gross Billable Income	4,431,674	33	13,332	40,183	121	10	
11	32	Interest	Gross Billable Income	4,431,674	33	22,225	40,183	202	11	
12	33	Real Estate Taxes	Gross Billable Income	4,431,674	33	2,521	40,183	23	12	
13	34	Rent - Building	Gross Billable Income	4,431,674	33	17,500	40,183	159	13	
14	35	Rent - Equipment	Gross Billable Income	4,431,674	33	4,277	40,183	39	14	
15	01	Dietary	Direct Billable Income	341,879	33	112,243	4,769	1,566	15	
16	02	Food	Direct Billable Income	25	33	8			16	
17	03	Housekeeping	Direct Billable Income	29	33	10			17	
18	10	Nursing	Direct Billable Income	69,616	33	22,856	805	264	18	
19	21	Clerical and General Office	Direct Billable Income	487	33	160			19	
20	25	Other Admin. Staff Transport.	Direct Billable Income	1,200	33	394			20	
21	39	Ancillary	Direct Billable Income	4,018,438	33	1,319,298	4,674	1,534	21	
22	17	Administrative	Gross Billable Income	4,431,674	33	155,031	155,031	40,183	1,406	22
23	21	Clerical and General Office	Gross Billable Income	4,431,674	33	219,270	219,270	40,183	1,988	23
24	27	Employee Benefits	Gross Billable Income	4,431,674	33	61,873	40,183	561	24	
25	TOTALS					\$ 2,152,809	\$ 374,301	\$ 9,693	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	06	Repairs	Direct Billing	892,186	27	\$ 35,557	\$	\$	1
2	21	Office and Clerical	Direct Billing	892,186	27	44			2
3	30	Depreciation	Direct Billing	892,186	27	280,000			3
4	32	Interest	Direct Billing	892,186	27	23,404			4
5	30	Depreciation	Patient Days	1,625,640	33	19,677	65,755	796	5
6	32	Interest	Patient Days	1,625,640	33	27,081	65,755	1,095	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					\$ 385,762	\$	\$ 1,891	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation			\$		\$ 243	1
2	3	Housekeeping	Direct Allocation					34,713	2
3	4	Laundry	Direct Allocation					2,601	3
4	6	Repairs & Maintenance	Direct Allocation					7,395	4
5	10	Nursing	Direct Allocation					22,378	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation					3,426	10
11	24	Seminars & Education	Direct Allocation					343	11
12	39	Ancillary	Direct Allocation					18,013	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					\$		\$ 89,112	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CCS Employee Benefits Group, Inc.  
 Street Address 2201 W. Main Street  
 City / State / Zip Code Evanston, IL 60202  
 Phone Number ( 847)905-4000  
 Fax Number ( 847)905-4040

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 66,105	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				\$	\$		\$ 66,105	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning:

01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT



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

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	<b>A. Directly Facility Related</b>												
	<b>Long-Term</b>												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	<b>TOTAL Long-Term</b>												
	<b>Working Capital</b>												
8	<b>Fox Vally Fire &amp; Safety</b>		X				\$	\$			\$	257	8
9												9	
10												10	
11												11	
12												12	
13												13	
14	<b>TOTAL Working Capital</b>												
	<b>B. Non-Facility Related*</b>												
15	<b>Care Centers, Inc.</b>		X				\$	\$			\$	37,994	15
16	<b>Care Centers Clinical</b>		X									3,642	16
17	<b>Care Centers Health Systems Inc.</b>		X									202	17
18	<b>Vent Lease, LLC</b>		X									1,095	18
19												19	
20	<b>TOTAL Non-Facility Related</b>												

\* 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.)

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

B. Real Estate Taxes

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2006 report.		\$ 134,564	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.)		\$ 199,842	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 65,278	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 108,170	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$ 12,000	5
6. Subtract a refund of real estate taxes. 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. <b>TOTAL REFUND \$ 9,727 For 2003 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 185,448	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	250,628	8
	2003	214,787	9
	2004	219,588	10
	2005	221,794	11
	2006	196,673	12
<u>Beginning accrual adjusted due to payment of 2006 2nd Installment and 2007 1st Installment</u>			
<u>CC Clinical Allocation \$199 CC Health Systems Allocation \$23</u>			
<u>Care Centers Allocation \$2,947</u>			
<u>2003 Not a Rate Setting Year, does not affect Accrual.</u>			
		<b>FOR BHF USE ONLY</b>	
	13	FROM R. E. TAX STATEMENT FOR 2006 \$	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.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Sheridan Shores Care & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040444

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2006 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2006.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>14-05-402-027-0000</u>	<u>Long Term Care Property</u>	\$ <u>98,336.51</u>	\$ <u>98,336.51</u>
2. <u>14-05-402-028-0000</u>	<u>Long Term Care Property</u>	\$ <u>98,336.51</u>	\$ <u>98,336.51</u>
3. <u>Home Office Allocation</u>	<u>Care Centers, Inc.</u>	\$ <u>46,662.50</u>	\$ <u>1,887.44</u>
4. <u>Home Office Allocation</u>	<u>Care Centers Building, LLC</u>	\$ <u>24,152.48</u>	\$ <u>976.94</u>
5. <u>Home Office Allocation</u>	<u>Care Centers Health Systems, LLC</u>	\$ <u>2,476.87</u>	\$ <u>22.46</u>
6. <u>Home Office Allocation</u>	<u>Care Centers Clinical, Inc.</u>	\$ <u>4,834.42</u>	\$ <u>195.55</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u>274,799.29</u>	\$ <u>199,755.41</u>

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Sheridan Shores Care & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040444

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

**A. Summary of Real Estate Tax Cost**

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

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

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444 Report Period Beginning:

01/01/07 Ending:

12/31/07

**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, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>			\$ <u>690,923</u>	1
2	<u>Care Centers Allocation</u>			<u>16,307</u>	2
3	<b>TOTALS</b>			\$ <b>707,230</b>	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$		4
5											5
6											6
7											7
8											8
		<b>Improvement Type**</b>									
9	Various		1993		42,874		20	2,145	2,145	30,742	9
10	Various		1994		57,552		20	2,878	2,878	39,081	10
11	Various		1995		146,433		20	7,322	7,322	92,652	11
12	Various		1996		67,704		20	3,385	3,385	39,251	12
13	Various		1997		53,902		20	2,696	2,696	28,433	13
14	Various		1998		172,679		20	8,637	8,637	82,862	14
15	Various		1999		62,682		20	3,134	3,134	26,836	15
16	Various		2000		149,525		20	7,503	7,503	56,408	16
17	Various		2001		56,462		20	2,823	2,823	19,139	17
18	Various		2002		66,781		20	6,259	6,259	37,962	18
19	Various		2003		90,561		20	13,082	13,082	60,351	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning:

01/01/07

Ending:

12/31/07

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
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51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		4,446,255	116,133		115,269	(864)	345,807	67
68		91,398	4,813		4,813		30,098	68
69			166,792			(166,792)		69
70		\$ 5,504,808	\$ 287,738		\$ 179,946	\$ (107,792)	\$ 889,622	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Sheridan Shores Care &amp; Rehab Ctr

# 0040444

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 5,504,808	\$ 287,738		\$ 179,946	\$ (107,792)	\$ 889,622	1
2	Repairs And Parts For Boiler	2004	658		20	132	132	515	2
3	Repairs And Parts For Exhaust Fans	2004	1,227		20	245	245	961	3
4	Bypass Hoses & Exhaust System	2004	2,814		20	563	563	2,204	4
5	Installation Of Iron Fence	2004	3,790		20	379	379	1,484	5
6	New Motor	2004	926		20	185	185	710	6
7	Repair Of Air Conditioning System	2004	1,768		20	354	354	1,326	7
8	Elevator Repairs	2004	500		20	100	100	367	8
9	Generator Maintenance	2004	1,171		20	234	234	839	9
10	Repair On Walk-In-Freezer	2004	501		20	100	100	359	10
11	Removal Of Heavy Duty Shoring	2004	3,373		20	337	337	1,181	11
12	Elevator Repair	2004	604		20	60	60	211	12
13	Elevator Repair	2004	604		20	121	121	413	13
14	Fire Service Upgrade	2004	35,300		20	3,530	3,530	12,061	14
15	New Compressor	2004	1,826		20	365	365	1,248	15
16	Heater Repair And Parts	2004	1,480		20	148	148	506	16
17	Door Signs	2004	544		20	109	109	372	17
18	Shower & Tub Rooms	2004	560		20	56	56	187	18
19	Tower & Exhaust Repairs	2004	614		20	61	61	205	19
20	Small Passenger Elevator Repairs	2004	1,661		20	166	166	540	20
21	Large Passenger Elevator Repairs	2004	955		20	95	95	310	21
22	Small Passenger Elevator Repairs	2004	604		20	60	60	196	22
23	Large Passenger Elevator Repairs	2004	1,435		20	144	144	466	23
24	Water Pump Repairs	2004	1,173		20	117	117	381	24
25	Safety Glass	2004	560		20	56	56	182	25
26	Elevator Repair	2004	623		20	62	62	197	26
27	Small Passenger Elevator Repairs	2004	2,325		20	233	233	736	27
28	New Carpeting	2004	2,337		20	334	334	1,057	28
29	New Floor Tile	2004	1,627		20	108	108	343	29
30	Generator Maintenance	2004	791		20	79	79	251	30
31	Fire Alarm System	2004	2,100		20	210	210	648	31
32	Small Elevator Repairs	2004	5,425		20	271	271	836	32
33	Large Elevator Repairs	2004	1,214		20	61	61	187	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,585,898	\$ 287,738		\$ 189,021	\$ (98,717)	\$ 921,101	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Sheridan Shores Care &amp; Rehab Ctr

# 0040444

Report Period Beginning:

01/01/07

Ending:

12/31/07

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 5,585,898	\$ 287,738		\$ 189,021	\$ (98,717)	\$ 921,101	1
2	Circulating Pump In Boiler Room	2004	3,015		20	251	251	775	2
3	Domestic Hot Water	2004	526		20	44	44	135	3
4	Door Magnets, Wiring	2004	200		20	20	20	72	4
5	Wiring	2004	295		20	30	30	106	5
6	Wiring	2004	380		20	38	38	136	6
7	Acoustical And Drywall	2004	386		20	39	39	138	7
8	Acoustical And Drywall	2004	386		20	39	39	138	8
9	Condensor Fan Motor	2004	344		20	34	34	123	9
10	Scaffolding	2004	6,614		20	661	661	2,370	10
11	Wiring	2004	625		20	63	63	224	11
12	Fire Alarm	2005	7,870		20	787	787	2,361	12
13	Reface Cabinets & Counter Tops	2005	3,600		20	720	720	2,100	13
14	Elevator Repair	2005	7,918		20	792	792	2,243	14
15	Hot Water System (Reclass From F&E)	2005	6,083		20	608	608	1,622	15
16	Leasehold Improvements	2005	2,656		20	266	266	620	16
17	Seco Refrigeration	2005	3,382		20	338	338	789	17
18	Anerson Elevator	2005	6,495		20	650	650	1,516	18
19	Parking Garage	2005	381,112		20	19,056	19,056	46,051	19
20	Additional Garage Costs	2005	53,203		20	2,660	2,660	5,542	20
21	Water Heater Repair	2005	2,674		20	134	134	301	21
22	Pump Repair	2005	1,859		20	93	93	201	22
23	Boiler Repair	2005	1,874		20	94	94	195	23
24	Curtains	2005	1,966		20	98	98	213	24
25	Rebuilt Circulating Pump	2005	2,106		20	105	105	386	25
26	Repair Air Conditioner	2005	583		20	29	29	107	26
27	Repair Hot Water Heater	2005	774		20	39	39	143	27
28	Repairs To Boiler & Roof Exhausts	2005	1,273		20	64	64	234	28
29	Motor Repairs	2005	1,035		20	52	52	190	29
30	Elevator Motor Repair	2005	279		20	14	14	105	30
31	Repairs To Hot Water Booster	2005	884		20	44	44	147	31
32	Repair Fire Sprinkler	2005	1,195		20	60	60	200	32
33	Repairs To Generator	2005	2,548		20	127	127	254	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,090,038	\$ 287,738		\$ 217,069	\$ (70,669)	\$ 990,837	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 6,090,038	\$ 287,738		\$ 217,069	\$ (70,669)	\$ 990,837	1
2	15Th Payment On Garage Work	2006	36,749		20	3,675	3,675	6,125	2
3	Painting-Labor Only	2006	14,000		20	1,400	1,400	2,217	3
4	1 Cookson Coiling Service Door & Sensor	2006	9,400		20	940	940	1,488	4
5	Ligat Architects-Consulting On Garage Repairs	2006	14,432		20	1,443	1,443	2,045	5
6	Byme Johson Roofing	2006	4,350		20	435	435	580	6
7	Plumbing Repairs	2006	6,454		20	1,291	1,291	2,367	7
8	Parking Garage Repair	2006	29,553		20	2,955	2,955	3,448	8
9	Installation And Relocation Of Sprinkler Heads	2006	12,750		20	1,275	1,275	1,381	9
10	Spirnkler Repairs - Connect Canopy To Antifreeze Loop	2006	2,800		20	280	280	303	10
11	Install Smoke Detector In Elevator Shaft	2006	1,669		20	167	167	181	11
12	Automatic Transfer Switch	2006	2,563		20	256	256	278	12
13	Rebuilt House Pump #2	2006	3,406		20	341	341	369	13
14	Fire Spinkler Modification	2006	16,645		20	1,665	1,665	2,081	14
15	Hot Water Tank, Valve, Piping Repairs	2007	7,406		20	617	617	617	15
16	Pump Repair	2007	2,672		20	200	200	200	16
17	Replace Leaking Sewer Lines	2007	12,861		20	857	857	857	17
18	Water Pump & Gasket, Generator Emer Srvc	2007	3,232		20	215	215	215	18
19	A/C Repair	2007	3,264		20	113	113	113	19
20	Sprinkler System Repair	2007	2,420		20	101	101	101	20
21	Generator Repairs	2007	3,161		20	151	151	151	21
22	Pipe Repairs In Ceiling Of Maint Rm	2007	2,500		20	83	83	83	22
23	Repaired & Replaced Pumps In Boiler Room	2007	3,012		20	25	25	25	23
24	Reclass - Recovering Of Awning	2007	2,950		20	49	49	49	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,288,287	\$ 287,738		\$ 235,603	\$ (52,135)	\$ 1,016,111	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning:

01/01/07

Ending:

12/31/07

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 6,288,287	\$ 287,738		\$ 235,603	\$ (52,135)	\$ 1,016,111	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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10									10
11									11
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,288,287	\$ 287,738		\$ 235,603	\$ (52,135)	\$ 1,016,111	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12E, Carried Forward	\$ 6,288,287	\$ 287,738		\$ 235,603	\$ (52,135)	\$ 1,016,111	1	
2								2	
3								3	
4								4	
5								5	
6								6	
7								7	
8								8	
9								9	
10								10	
11								11	
12								12	
13								13	
14								14	
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16								16	
17								17	
18								18	
19								19	
20								20	
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24								24	
25								25	
26								26	
27								27	
28								28	
29								29	
30								30	
31								31	
32								32	
33								33	
34	TOTAL (lines 1 thru 33)	\$ 6,288,287	\$ 287,738		\$ 235,603	\$ (52,135)	\$ 1,016,111	34	

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning:

01/01/07

Ending:

12/31/07

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12F, Carried Forward</b>		\$ 6,288,287	\$ 287,738		\$ 235,603	\$ (52,135)	\$ 1,016,111	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,288,287	\$ 287,738		\$ 235,603	\$ (52,135)	\$ 1,016,111	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning:

01/01/07

Ending:

12/31/07

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12G, Carried Forward</b>		\$ 6,288,287	\$ 287,738		\$ 235,603	\$ (52,135)	\$ 1,016,111	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,288,287	\$ 287,738		\$ 235,603	\$ (52,135)	\$ 1,016,111	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning:

01/01/07

Ending:

12/31/07

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12H, Carried Forward</b>		\$ 6,288,287	\$ 287,738		\$ 235,603	\$ (52,135)	\$ 1,016,111	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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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	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,288,287	\$ 287,738		\$ 235,603	\$ (52,135)	\$ 1,016,111	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning:

01/01/07

Ending:

12/31/07

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12I, Carried Forward</b>	\$ 6,288,287	\$ 287,738		\$ 235,603	\$ (52,135)	\$ 1,016,111		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>	\$ 6,288,287	\$ 287,738		\$ 235,603	\$ (52,135)	\$ 1,016,111		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 6,288,287	\$ 287,738		\$ 235,603	\$ (52,135)	\$ 1,016,111	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,288,287	\$ 287,738		\$ 235,603	\$ (52,135)	\$ 1,016,111	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning:

01/01/07

Ending:

12/31/07

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12K, Carried Forward</b>		\$ 6,288,287	\$ 287,738		\$ 235,603	\$ (52,135)	\$ 1,016,111	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,288,287	\$ 287,738		\$ 235,603	\$ (52,135)	\$ 1,016,111	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning:

01/01/07

Ending:

12/31/07

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12L, Carried Forward</b>		\$ 6,288,287	\$ 287,738		\$ 235,603	\$ (52,135)	\$ 1,016,111	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,288,287	\$ 287,738		\$ 235,603	\$ (52,135)	\$ 1,016,111	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12M, Carried Forward		\$ 6,288,287	\$ 287,738		\$ 235,603	\$ (52,135)	\$ 1,016,111	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,288,287	\$ 287,738		\$ 235,603	\$ (52,135)	\$ 1,016,111	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning:

01/01/07

Ending:

12/31/07

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12N, Carried Forward</b>		\$ 6,288,287	\$ 287,738		\$ 235,603	\$ (52,135)	\$ 1,016,111	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,288,287	\$ 287,738		\$ 235,603	\$ (52,135)	\$ 1,016,111	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12O, Carried Forward		\$ 6,288,287	\$ 287,738		\$ 235,603	\$ (52,135)	\$ 1,016,111	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,288,287	\$ 287,738		\$ 235,603	\$ (52,135)	\$ 1,016,111	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12P, Carried Forward		\$ 6,288,287	\$ 287,738		\$ 235,603	\$ (52,135)	\$ 1,016,111	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,288,287	\$ 287,738		\$ 235,603	\$ (52,135)	\$ 1,016,111	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	191		2005	1977	\$ 4,394,436	\$ 112,678	39	\$ 112,678	\$	\$ 338,034	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Site Improvements		2005		51,819	3,455		2,591	(864)	7,773	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning:

01/01/07

Ending:

12/31/07

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	<b>TOTAL (lines 4 thru 69)</b>	\$	4,446,255	\$	116,133	\$	115,269	\$	(864)	\$	345,807	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4		2201 Main LLC Allocation	2002	2002	\$ 18,012	\$ 462		\$ 462	\$	\$ 2,444	4
5		Care Centers Clinical Allocation	2002	2002	1,866	48		48		253	5
6		Care Centers Health Systems Allocation	2002	2002	214	5		5		29	6
7		Hillside (Storage and Training)	1996	1996	30,542	783		783		8,647	7
8											8
		Improvement Type**									
9		Care Centers Health Systems Allocation		2002	177	16	20	16		81	9
10		Care Centers Health Systems Allocation		2003	209	19	20	19		96	10
11		Care Centers Health Systems Allocation		2005	10	1	20	1		3	11
12											12
13		Care Centers Clinical Allocation		2002	1,542	141	20	141		706	13
14		Care Centers Clinical Allocation		2003	1,817	166	20	166		832	14
15		Care Centers Clinical Allocation		2005	90	10	20	10		23	15
16											16
17		2201 Main LLC Allocation		2002	14,879	1,360	20	1,360		6,812	17
18		2202 Main LLC Allocation		2003	17,535	1,602	20	1,602		8,028	18
19		2203 Main LLC Allocation		2005	871	93	20	93		221	19
20											20
21		Care Centers, Inc.		2007	186	12	20	12		12	21
22											22
23		Hillside (Storage and Training)		1996	515	-	20	-		515	23
24		Hillside (Storage and Training)		1997	2,933	95	20	95		1,396	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning:

01/01/07

Ending:

12/31/07

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9			
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation			
37		\$	\$		\$	\$	\$	37		
38								38		
39								39		
40								40		
41								41		
42								42		
43								43		
44								44		
45								45		
46								46		
47								47		
48								48		
49								49		
50								50		
51								51		
52								52		
53								53		
54								54		
55								55		
56								56		
57								57		
58								58		
59								59		
60								60		
61								61		
62								62		
63								63		
64								64		
65								65		
66								66		
67								67		
68								68		
69								69		
70	<b>TOTAL (lines 4 thru 69)</b>	\$	<b>91,398</b>	\$	<b>4,813</b>	\$	<b>4,813</b>	\$	<b>30,098</b>	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/07 Ending: 12/31/07

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,261,020	\$ 141,382	\$ 131,208	\$ (10,174)	10	\$ 743,874	71
72	Current Year Purchases	10,720	151	490	339	10	490	72
73	Fully Depreciated Assets	83,502				10	83,502	73
74								74
75	TOTALS	\$ 1,355,242	\$ 141,533	\$ 131,698	\$ (9,835)		\$ 827,866	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Care Centers Clinical	Allocation	2007	\$ 2,908	\$ 430	\$ 430	\$	5	\$ 549	76
77	Care Centers Health Sys.	Allocation	2007	114	4	4		5	4	77
78	Care Centers, Inc.	Allocation	2007	33,981	1,971	1,971		5	27,913	78
79										79
80	TOTALS			\$ 37,003	\$ 2,405	\$ 2,405	\$		\$ 28,466	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,387,762	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 431,676	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 369,707	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (61,969)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,872,444	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Care Centers Allocation				3,342			5
6								6
7	TOTAL				\$ 3,342			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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 2,313 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 52,506	\$		\$ 52,506	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			605			605	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			72,351			72,351	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				100,415		100,415	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <a href="#">See Supplemental</a>						33,940		33,940	13
14	<b>TOTAL</b>			\$		\$ 125,462	\$ 134,355		\$ 259,817	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr# 0040444Report Period Beginning: 01/01/07

Ending:

12/31/07

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,517	\$ 367,800	1
2	Cash-Patient Deposits	51,149	51,149	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	969,032	1,077,202	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	96,928	96,928	6
7	Other Prepaid Expenses	20,208	20,208	7
8	Accounts Receivable (owners or related parties)		1,000	8
9	Other(specify): <u>See Attached Schedule</u>	51,414	108,380	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,190,248	\$ 1,722,667	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		690,923	13
14	Buildings, at Historical Cost		4,394,437	14
15	Leasehold Improvements, at Historical Cost	1,560,088	1,611,907	15
16	Equipment, at Historical Cost	816,174	1,403,458	16
17	Accumulated Depreciation (book methods)	(1,552,475)	(2,206,083)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	4,145,537	4,702,325	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 4,969,324	\$ 10,596,967	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 6,159,572	\$ 12,319,634	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 593,239	\$ 593,237	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	45,397	45,397	28
29	Short-Term Notes Payable	1,373,656	1,373,656	29
30	Accrued Salaries Payable	197,313	197,313	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,769	11,769	31
32	Accrued Real Estate Taxes(Sch.IX-B)		108,170	32
33	Accrued Interest Payable	123,254	182,003	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	4,737,844	211,458	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 7,082,472	\$ 2,723,003	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	585,000	585,000	39
40	Mortgage Payable		10,382,731	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 585,000	\$ 10,967,731	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 7,667,472	\$ 13,690,734	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (1,507,900)	\$ (1,371,100)	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 6,159,572	\$ 12,319,634	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,659,699)	1
2	Restatements (describe):		2
3	<u>2005 Interest</u>	(144,880)	3
4	<u>2005 Office Expense</u>	(651)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,805,230)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	297,330	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)	\$ 297,330	17
<b>B. Transfers (Itemize):</b>			
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)	\$ (1,507,900)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr# 0040444Report Period Beginning: 01/01/07Ending: 12/31/07**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,779,891	1
2	Discounts and Allowances for all Levels	(650,200)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 7,129,691</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	583,776	6
7	Oxygen	14,187	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 597,963</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,650	16
17	Sale of Drugs	97,613	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,464	19
20	Radiology and X-Ray	1,080	20
21	Other Medical Services	6,867	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 118,674</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 1</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	41,062	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 41,062</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 7,887,391</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,395,791	31
32	Health Care	2,585,416	32
33	General Administration	1,637,447	33
<b>B. Capital Expense</b>			
34	Ownership	1,607,017	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	259,817	35
36	Provider Participation Fee	104,573	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 7,590,061</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>297,330</b>	<b>41</b>
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 297,330</b>	<b>43</b>

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

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

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

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

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning: 01/01/07

Ending: 12/31/07

**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	2,010	2,157	\$ 67,310	\$ 31.21	1
2	Assistant Director of Nursing	1,757	2,044	62,272	30.47	2
3	Registered Nurses	8,584	10,197	255,627	25.07	3
4	Licensed Practical Nurses	31,535	36,762	842,189	22.91	4
5	CNAs & Orderlies	71,566	78,413	744,579	9.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,516	10,956	155,271	14.17	8
9	Activity Director	2,022	2,333	37,753	16.18	9
10	Activity Assistants	5,880	6,407	57,364	8.95	10
11	Social Service Workers	17,596	18,925	248,169	13.11	11
12	Dietician					12
13	Food Service Supervisor	1,981	2,222	40,424	18.19	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,670	6,174	59,447	9.63	15
16	Dishwashers	14,633	15,966	137,314	8.60	16
17	Maintenance Workers	14,033	15,610	193,737	12.41	17
18	Housekeepers	20,239	22,015	180,826	8.21	18
19	Laundry	7,156	7,997	76,100	9.52	19
20	Administrator	2,061	2,144	95,353	44.47	20
21	Assistant Administrator	840	1,000	8,500	8.50	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,754	9,018	123,909	13.74	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,737	2,094	33,395	15.95	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	226,570	252,434	\$ 3,419,539 *	\$ 13.55	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	183	\$ 10,709	01-03	35
36	Medical Director	Monthly	3,600	09-03	36
37	Medical Records Consultant	Monthly	1,331	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,721	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	13,894	12-03	45
46	Other(specify)				46
47	Psychiatrist	36	3,600	10-03	47
48	Therapy Consultant	19	756	10a-03	48
49	TOTAL (lines 35 - 48)	238	\$ 36,611		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning: 01/01/07

Ending: 12/31/07

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Corey J. Nigro	Administrator	0	\$ 95,353	Workers' Compensation Insurance	\$ 60,579	IDPH License Fee	\$ 1,327		
Nathan Langsner	Assist. Admin	0	8,500	Unemployment Compensation Insurance	62,280	Advertising: Employee Recruitment	5,548		
				FICA Taxes	259,609	Health Care Worker Background Check			
				Employee Health Insurance	127,795	(Indicate # of checks performed <u>397</u> )	5,016		
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	11,143		
				Chicago Head Tax	2,860	Licenses & Fees	4,184		
				Union Pension	25,740	Advertising & Promotion	14,304		
				Other Employee Welfare	7,196	Care Centers Allocation	7,257		
				Holiday Expense	2,577				
				Employee Physicals	7,709	Less: Public Relations Expense	( )		
				Pension Expense	29	Non-allowable advertising	(14,304)		
						Yellow page advertising	( )		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)			
					\$ 103,853				
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)					
					\$ 60,000				
Description				Amount					
Nachum Langsner- Management Fees				\$ 60,000					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 60,000					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
FR & R	Accounting		\$ 15,000				Out-of-State Travel	\$	
ADP	Payroll Services		11,979						
eHealth Data Solutions	Data Processing		1,590						
Chad Cournaya	Medicare Consultant		131				In-State Travel		
National Datacare Corp	Data Processing		2,746						
Personnel Planners	Unemployment Consult.		1,924						
Prospect Resources	Natural Gas Procurement		700						
HFG	Line of Credit/Audit		4,851				Seminar Expense	6,760	
Admiral Environmental Serv.	Environ. Compliance Cnsltg		117				Care Centers Allocation	1,815	
Allegiance	Employee Compliance		155						
Care Centers, Inc	Home Office Expense		70,101						
See Supplemental Schedule			52,537				Entertainment Expense	( )	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)	
								\$ 8,575	

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

Report Period Beginning: 01/01/07 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IL Council on Long Term Care \$10,340
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Yes If YES, what is the capacity? 191
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,078 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 X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 104,573  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ \_\_\_\_\_ Has any meal income been offset against related costs? No 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? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ No**
- (17) Has an audit been performed by an independent certified public accounting firm? \_\_\_\_\_  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT