



Facility Name & ID Number Sheridan Shores Care & Rehab Ctr# 0040444 Report Period Beginning: 01/01/08 Ending: 12/31/08

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed bedsN/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>23,058</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>128</u>	Intermediate (ICF)	<u>128</u>	<u>46,848</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>69,906</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>60,263</u>	<u>1,501</u>	<u>1,455</u>	<u>63,219</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>60,263</u>	<u>1,501</u>	<u>1,455</u>	<u>63,219</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 90.43%

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

1,552 (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)

NoneF. Does the facility maintain a daily midnight census? YesG. 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 05/01/1993

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

YES  Date 05/01/1993 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 1,455Medicare Intermediary National Government Services

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED  
CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/08 Ending: 12/31/08

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	243,383	42,701	14,577	300,661		300,661	(173)	300,488		1
2	Food Purchase		292,552		292,552		292,552	471	293,023		2
3	Housekeeping	190,550	48,965		239,515		239,515	(3,501)	236,014		3
4	Laundry	79,198	24,081		103,279		103,279	(89)	103,190		4
5	Heat and Other Utilities			251,310	251,310		251,310	3,445	254,755		5
6	Maintenance	203,306	82	169,288	372,676		372,676	10,057	382,733		6
7	Other (specify):*							2,969	2,969		7
8	<b>TOTAL General Services</b>	<b>716,437</b>	<b>408,381</b>	<b>435,175</b>	<b>1,559,993</b>		<b>1,559,993</b>	<b>13,178</b>	<b>1,573,171</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	2,125,039	46,978	20,405	2,192,422		2,192,422	30,269	2,222,691		10
10a	Therapy	109,884			109,884		109,884	2,864	112,748		10a
11	Activities	103,737	12,913		116,650		116,650		116,650		11
12	Social Services	221,849	5,259	18,239	245,347		245,347	16,634	261,981		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							7,376	7,376		15
16	<b>TOTAL Health Care and Programs</b>	<b>2,560,509</b>	<b>65,150</b>	<b>42,244</b>	<b>2,667,903</b>		<b>2,667,903</b>	<b>57,143</b>	<b>2,725,046</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	122,649		50,000	172,649		172,649	62,138	234,787		17
18	Directors Fees										18
19	Professional Services			356,456	356,456		356,456	(252,613)	103,843		19
20	Dues, Fees, Subscriptions & Promotions			50,598	50,598		50,598	(11,695)	38,903		20
21	Clerical & General Office Expenses	97,025	40,013	343,212	480,250		480,250	(47,956)	432,294		21
22	Employee Benefits & Payroll Taxes			553,583	553,583		553,583	(10,415)	543,168		22
23	Inservice Training & Education										23
24	Travel and Seminar			21,098	21,098		21,098	1,478	22,576		24
25	Other Admin. Staff Transportation			2,593	2,593		2,593	1,632	4,225		25
26	Insurance-Prop.Liab.Malpractice			179,976	179,976		179,976	1,253	181,229		26
27	Other (specify):*							39,052	39,052		27
28	<b>TOTAL General Administration</b>	<b>219,674</b>	<b>40,013</b>	<b>1,557,516</b>	<b>1,817,203</b>		<b>1,817,203</b>	<b>(217,126)</b>	<b>1,600,077</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,496,620</b>	<b>513,544</b>	<b>2,034,935</b>	<b>6,045,099</b>		<b>6,045,099</b>	<b>(146,805)</b>	<b>5,898,294</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: 01/01/08 Ending: 12/31/08

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			161,645	161,645	161,645	203,306	364,951			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			94,623	94,623	94,623	741,529	836,152			32
33	Real Estate Taxes			192,369	192,369	192,369	5,174	197,543			33
34	Rent-Facility & Grounds			1,104,782	1,104,782	1,104,782	(1,100,660)	4,122			34
35	Rent-Equipment & Vehicles			2,056	2,056	2,056	1,291	3,347			35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			1,555,475	1,555,475	1,555,475	(149,360)	1,406,115			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		108,789	56,164	164,953	164,953	(5,981)	158,972			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			104,860	104,860	104,860		104,860			42
43	Other (specify):*			648	648	648	(648)				43
44	<b>TOTAL Special Cost Centers</b>		108,789	161,672	270,461	270,461	(6,629)	263,832			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,496,620	622,333	3,752,082	7,871,035	7,871,035	(302,794)	7,568,241			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: 01/01/08

Ending: 12/31/08

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(13,163)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(69)	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	(16,380)	21		18
19	Entertainment				19
20	Contributions	(1,073)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(160,038)	21		24
25	Fund Raising, Advertising and Promotional	(10,665)	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	(134,434)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (335,823)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	33,029		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 33,029		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (302,794)		37

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

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

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

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

## Sheridan Shores Care &amp; Rehab Ctr

ID# 0040444

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Rental Income	\$ (125)	06	1
2	Miscellaneous Income	(5,829)	21	2
3	Patient Clothing	(958)	10	3
4	Theft Loss	(256)	21	4
5	Collection Expense	(47)	21	5
6	Jury Duty Income	(17)	10	6
7	Annual Report	(250)	20	7
8	COPE Dues	(6,825)	20	8
9	Building Co. - Bank Fees	(50)	21	9
10	Building Co. - Filing Fees	(250)	21	10
11	Building Co. - Amortization	(62,653)	36	11
12	2009 Seminar Fees	(729)	24	12
13	Public Relations	(648)	43	13
14	Non-Allowable Legal Fees	(63)	19	14
15	Non-Allowable Expense	(50,000)	21	15
16	2008 Seminar Booked in 2007	199	24	16
17	Non-Allowable Interest	(5,933)	32	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(134,434)		49

Sheridan Shores Care & Rehab Ctr

ID# 0040444

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES	Amount	Reference	Sch. V Line
50	\$		1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

## STATE OF ILLINOIS

Summary A

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

# 0040444

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary			533		3,911	(4,609)	(8)					(173)	1
2	Food Purchase	(69)		540									471	2
3	Housekeeping			528		59		(4,088)					(3,501)	3
4	Laundry							(89)					(89)	4
5	Heat and Other Utilities			3,209		133	103						3,445	5
6	Maintenance	(125)		4,054	7,827	17	18	(1,734)					10,057	6
7	Other (specify):*				2,463	506							2,969	7
8	<b>TOTAL General Services</b>	<b>(194)</b>		<b>8,864</b>	<b>10,290</b>	<b>4,626</b>	<b>(4,488)</b>	<b>(5,919)</b>					<b>13,178</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(975)				33,531		(2,287)					30,269	10
10a	Therapy					2,864							2,864	10a
11	Activities													11
12	Social Services					16,634							16,634	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					7,376							7,376	15
16	<b>TOTAL Health Care and Programs</b>	<b>(975)</b>				<b>60,405</b>		<b>(2,287)</b>					<b>57,143</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			2,551	9,515	48,591	1,481						62,138	17
18	Directors Fees													18
19	Professional Services	(63)		(142,339)		(110,268)	57						(252,613)	19
20	Fees, Subscriptions & Promotions	(18,813)		7,059		9	50						(11,695)	20
21	Clerical & General Office Expenses	(232,850)	300	30,807	148,070	16,506	1,757	(1)		(12,545)			(47,956)	21
22	Employee Benefits & Payroll Taxes				(9,660)	(518)		(237)					(10,415)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(530)		1,802		206							1,478	24
25	Other Admin. Staff Transportation			1,535			97						1,632	25
26	Insurance-Prop.Liab.Malpractice			1,115		18	120						1,253	26
27	Other (specify):*				30,261	8,382	409						39,052	27
28	<b>TOTAL General Administration</b>	<b>(252,256)</b>	<b>300</b>	<b>(97,470)</b>	<b>178,186</b>	<b>(37,074)</b>	<b>3,971</b>	<b>(237)</b>		<b>(12,545)</b>			<b>(217,126)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(253,425)</b>	<b>300</b>	<b>(88,606)</b>	<b>188,476</b>	<b>27,957</b>	<b>(517)</b>	<b>(8,444)</b>		<b>(12,545)</b>			<b>(146,805)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/08 Ending: 12/31/08

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(13,163)	192,245	14,567		989	110			8,558			203,306	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(5,933)	697,869	39,878		7,389	337			1,989			741,529	32
33	Real Estate Taxes			4,958		216							5,174	33
34	Rent-Facility & Grounds		(1,104,782)	3,767			355						(1,100,660)	34
35	Rent-Equipment & Vehicles			1,257			34						1,291	35
36	Other (specify):*	(62,653)	62,653											36
37	<b>TOTAL Ownership</b>	<b>(81,749)</b>	<b>(152,015)</b>	<b>64,427</b>		<b>8,594</b>	<b>836</b>			<b>10,547</b>			<b>(149,360)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(3,050)	(2,931)					(5,981)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(648)											(648)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(648)</b>					<b>(3,050)</b>	<b>(2,931)</b>					<b>(6,629)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(335,823)</b>	<b>(151,715)</b>	<b>(24,179)</b>	<b>188,476</b>	<b>36,551</b>	<b>(2,731)</b>	<b>(11,375)</b>		<b>(1,998)</b>			<b>(302,794)</b>	<b>45</b>

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning:

01/01/08

Ending:

12/31/08

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 1,104,782	Sheridan Shores Property LLC	100.00%	\$	\$ (1,104,782)	1
2	V	21 Bank Fees		Sheridan Shores Property LLC	100.00%	50	50	2
3	V	21 Filing Fees		Sheridan Shores Property LLC	100.00%	250	250	3
4	V	21 Replacement Tax		Sheridan Shores Property LLC	100.00%			4
5	V	30 Depreciation		Sheridan Shores Property LLC	100.00%	192,245	192,245	5
6	V	36 Amortization		Sheridan Shores Property LLC	100.00%	62,653	62,653	6
7	V	32 Interest Expense		Sheridan Shores Property LLC	100.00%	697,869	697,869	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,104,782			\$ 953,067	\$ * (151,715)	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: 01/01/08 Ending: 12/31/08

## VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	01	Dietary		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	\$ 533	\$ 533	15	
16	V	02	Food		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	540	540	16	
17	V	03	Housekeeping		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	528	528	17	
18	V	05	Utilities		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	3,209	3,209	18	
19	V	06	Maintenance		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	4,054	4,054	19	
20	V	17	Administrative		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	2,551	2,551	20	
21	V	19	Professional Fees	161,330	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	18,991	(142,339)	21	
22	V	20	Dues and Subscriptions		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	7,059	7,059	22	
23	V	21	Office and Clerical		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	30,807	30,807	23	
24	V	24	Seminar and Travel		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,802	1,802	24	
25	V	25	Other Staff Admin. Trans.		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,535	1,535	25	
26	V	26	Insurance		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,115	1,115	26	
27	V	30	Depreciation		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	14,567	14,567	27	
28	V	32	Interest		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	39,878	39,878	28	
29	V	33	Real Estate Taxes		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	4,958	4,958	29	
30	V	34	Rent - Building		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	3,767	3,767	30	
31	V	35	Rent - Equipment & Auto		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,257	1,257	31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			\$ 161,330			\$ 137,151	\$ * (24,179)	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: 01/01/08 Ending: 12/31/08

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	06 Maintenance (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	7,827	\$	7,827	15
16	V	06 Maintenance (Direct)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%				16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	2,463		2,463	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%				18
19	V	17 Administrative (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	9,515		9,515	19
20	V	21 Office and Clerical (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	148,070		148,070	20
21	V	21 Office and Clerical (Direct)	44,605	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	44,605			21
22	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	23,526		23,526	22
23	V	27 Emp. Ben. - Gen. Admin. (Direct)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	6,735		6,735	23
24	V	22 Employee Benefits	9,660	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%			(9,660)	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		\$ 54,265			\$ 242,741	\$ *	188,476	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: 01/01/08 Ending: 12/31/08

## VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	03	Housekeeping	\$	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	\$ 59	\$ 59	15	
16	V	05	Utilities		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	133	133	16	
17	V	06	Maintenance		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	17	17	17	
18	V	19	Professional Fees	111,784	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	1,516	(110,268)	18	
19	V	20	Dues and Subscriptions		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	9	9	19	
20	V	21	Office & Clerical		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	255	255	20	
21	V	24	Travel and Seminar		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	206	206	21	
22	V	26	Insurance		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	18	18	22	
23	V	30	Depreciation		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	989	989	23	
24	V	32	Interest		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	7,389	7,389	24	
25	V	33	Real Estate Taxes		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	216	216	25	
26	V	01	Dietary Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	3,911	3,911	26	
27	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	506	506	27	
28	V	10	Nursing Salary	3,977	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	37,508	33,531	28	
29	V	10a	Rehab Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	2,864	2,864	29	
30	V	12	Social Service Salary	2,306	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	18,940	16,634	30	
31	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	7,376	7,376	31	
32	V	17	Administration Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	48,591	48,591	32	
33	V	21	Office Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	16,251	16,251	33	
34	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	8,382	8,382	34	
35	V	22	Employee benefits	518	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%		(518)	35	
36	V								36	
37	V								37	
38	V								38	
39	Total			\$ 118,585			\$ 155,136	\$ * 36,551	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: 01/01/08 Ending: 12/31/08

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 Dietary	\$	Care Centers Health Systems, Inc.	100.00%	\$ 917	\$ 917	15
16	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%			16
17	V	05 Heat and Other Utilities		Care Centers Health Systems, Inc.	100.00%	103	103	17
18	V	06 Maintenance		Care Centers Health Systems, Inc.	100.00%	18	18	18
19	V	19 Professional Fees		Care Centers Health Systems, Inc.	100.00%	57	57	19
20	V	20 Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	50	50	20
21	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	225	225	21
22	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	97	97	22
23	V	26 Insurance		Care Centers Health Systems, Inc.	100.00%	120	120	23
24	V	30 Depreciation		Care Centers Health Systems, Inc.	100.00%	110	110	24
25	V	32 Interest		Care Centers Health Systems, Inc.	100.00%	337	337	25
26	V	33 Real Estate Taxes		Care Centers Health Systems, Inc.	100.00%			26
27	V	34 Rent - Building		Care Centers Health Systems, Inc.	100.00%	355	355	27
28	V	35 Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	34	34	28
29	V	01 Dietary	8,755	Care Centers Health Systems, Inc.	100.00%	3,229	(5,526)	29
30	V	02 Food		Care Centers Health Systems, Inc.	100.00%			30
31	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%			31
32	V	10 Nursing		Care Centers Health Systems, Inc.	100.00%			32
33	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%			33
34	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%			34
35	V	39 Ancillary	4,831	Care Centers Health Systems, Inc.	100.00%	1,781	(3,050)	35
36	V	17 Administrative		Care Centers Health Systems, Inc.	100.00%	1,481	1,481	36
37	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	1,532	1,532	37
38	V	27 Employee Benefits		Care Centers Health Systems, Inc.	100.00%	409	409	38
39	Total		\$ 13,586			\$ 10,855	\$ * (2,731)	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: 01/01/08 Ending: 12/31/08

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$ 87	Xcel Supply, LLC	100.00%	\$ 80	\$ (8)	15
16	V	3 Housekeeping	46,154	Xcel Supply, LLC	100.00%	42,066	(4,088)	16
17	V	4 Laundry	1,008	Xcel Supply, LLC	100.00%	919	(89)	17
18	V	6 Repairs & Maintenance	19,579	Xcel Supply, LLC	100.00%	17,844	(1,734)	18
19	V	10 Nursing	25,822	Xcel Supply, LLC	100.00%	23,535	(2,287)	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	10	Xcel Supply, LLC	100.00%	9	(1)	23
24	V	22 Employee Benefits	2,671	Xcel Supply, LLC	100.00%	2,434	(237)	24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary	33,086	Xcel Supply, LLC	100.00%	30,155	(2,931)	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		\$ 128,418			\$ 117,043	\$ * (11,375)	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: 01/01/08 Ending: 12/31/08

## VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 44,150	\$ 44,150	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	44,150	CCS Employee Benefits Group	100.00%		(44,150)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 44,150			\$ 44,150	\$ *	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	25	Auto Expense / Travel		Vent Lease, LLC.	100.00%			17
18	V	26	Insurance		Vent Lease, LLC.	100.00%			18
19	V	30	Depreciation		Vent Lease, LLC.	100.00%			19
20	V	32	Interest		Vent Lease, LLC.	100.00%			20
21	V	30	Depreciation - Matrix		Vent Lease, LLC.	100.00%	8,558	8,558	21
22	V	32	Interest - Matrix		Vent Lease, LLC.	100.00%	1,989	1,989	22
23	V	21	Office and Clerical	12,545	Vent Lease, LLC.	100.00%		(12,545)	23
24	V	39	Ancillary		Vent Lease, LLC.	100.00%			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		\$ 12,545				\$ 10,547	\$ * (1,998)	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.

**VII. RELATED PARTIES (continued)**

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

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

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

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

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/08 Ending: 12/31/08

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	Eric Rothner	Owner	Administrative	45.75%	See Attached	1.29	2.79%		\$	1
2	Adam Vales	Relative	Clerical	0.00%	See Attached	0.34	0.85%	Alloc. Salary	608	22-7
3	Mark Steinberg	Relative	Adminsitrative	0.00%	See Attached	2.13	3.87%	Alloc. Salary	5,908	17-7
4	Kim Rudolph	Relative	Clerical	0.00%	See Attached	0.14	0.83%	Alloc. Salary	123	22-7
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$ 6,639	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: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning:

01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,635,146	31	\$ 13,778	\$ 63,219	\$ 533	1
2	02	Food	Patient Days	1,635,146	31	13,971	63,219	540	2
3	03	Housekeeping	Patient Days	1,635,146	31	13,659	63,219	528	3
4	05	Utilities	Patient Days	1,635,146	31	83,022	63,219	3,209	4
5	06	Maintenance	Patient Days	1,635,146	31	104,857	63,219	4,054	5
6	17	Administrative	Patient Days	1,635,146	31	66,000	63,219	2,551	6
7	19	Professional Fees	Patient Days	1,635,146	31	491,332	63,219	18,991	7
8	20	Dues and Subscriptions	Patient Days	1,635,146	31	182,607	63,219	7,059	8
9	21	Office and Clerical	Patient Days	1,635,146	31	797,040	63,219	30,807	9
10	24	Seminar and Travel	Patient Days	1,635,146	31	46,589	63,219	1,802	10
11	25	Other Staff Admin. Trans.	Patient Days	1,635,146	31	39,698	63,219	1,535	11
12	26	Insurance	Patient Days	1,635,146	31	28,827	63,219	1,115	12
13	30	Depreciation	Patient Days	1,635,146	31	505,348	63,219	14,567	13
14	32	Interest	Patient Days	1,635,146	31	1,031,834	63,219	39,878	14
15	33	Real Estate Taxes	Patient Days	1,635,146	31	128,276	63,219	4,958	15
16	34	Rent - Building	Patient Days	1,635,146	31	97,438	63,219	3,767	16
17	35	Rent - Equipment & Auto	Patient Days	1,635,146	31	32,530	63,219	1,257	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,676,806	\$	\$ 137,151	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	06	Maintenance (Pooled)	Patient Days	1,635,146	31	202,448	202,448	63,219	7,827	1
2	06	Maintenance (Direct)	Direct		31	422,013	422,013			2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,635,146	31	63,663		63,219	2,463	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	53,015				4
5	17	Administrative (Pooled)	Patient Days	1,635,146	31	246,132	246,132	63,219	9,515	5
6	21	Office and Clerical (Pooled)	Patient Days	1,635,146	31	3,830,025	3,830,025	63,219	148,070	6
7	21	Office and Clerical (Direct)	Direct		31	695,305	695,305		44,605	7
8	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,635,146	31	608,507		63,219	23,526	8
9	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	90,171			6,735	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 6,211,280	\$ 5,395,924		\$ 242,741	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	03	Housekeeping	Patient Days	1,635,146	31	\$ 1,505	\$ 63,219	\$ 59	1
2	05	Utilities	Patient Days	1,635,146	31	3,449	63,219	133	2
3	06	Maintenance	Patient Days	1,635,146	31	431	63,219	17	3
4	19	Professional Fees	Patient Days	1,635,146	31	39,159	63,219	1,516	4
5	20	Dues and Subscriptions	Patient Days	1,635,146	31	244	63,219	9	5
6	21	Office & Clerical	Patient Days	1,635,146	31	6,594	63,219	255	6
7	24	Travel and Seminar	Patient Days	1,635,146	31	5,327	63,219	206	7
8	26	Insurance	Patient Days	1,635,146	31	465	63,219	18	8
9	30	Depreciation	Patient Days	1,635,146	31	25,565	63,219	989	9
10	32	Interest	Patient Days	1,635,146	31	191,164	63,219	7,389	10
11	33	Real Estate Taxes	Patient Days	1,635,146	31	5,595	63,219	216	11
12	01	Dietary Salary	Patient Days	1,635,146	31	101,177	101,177	3,911	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	1,635,146	31	13,096	63,219	506	13
14	10	Nursing Salary	Patient Days	1,635,146	31	867,390	867,390	33,531	14
15	10a	Rehab Salary	Patient Days	1,635,146	31	74,072	74,072	2,864	15
16	12	Social Service Salary	Patient Days	1,635,146	31	430,372	430,372	16,634	16
17	15	Emp. Ben. - Healthcare	Patient Days	1,635,146	31	177,415	63,219	6,858	17
18	17	Administration Salary	Patient Days	1,635,146	31	1,257,059	1,257,059	48,591	18
19	21	Office Salary	Patient Days	1,635,146	31	420,417	420,417	16,251	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	1,635,146	31	216,825	63,219	8,382	20
21	10	Nursing Salary	Direct Allocation			401,447	401,447	3,977	21
22	12	Social Service Salary	Direct Allocation			61,016	61,016	2,306	22
23	15	Emp. Ben. - Healthcare	Direct Allocation			51,816		518	23
24									24
25	TOTALS					\$ 4,351,600	\$ 3,612,950	\$ 155,136	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Gross Billable Income	31	3,867,056	111,096	31,920	917	1
2	03	Housekeeping	Gross Billable Income	31	3,867,056		31,920		2
3	05	Heat and Other Utilities	Gross Billable Income	31	3,867,056	12,529	31,920	103	3
4	06	Maintenance	Gross Billable Income	31	3,867,056	2,136	31,920	18	4
5	19	Professional Fees	Gross Billable Income	31	3,867,056	6,873	31,920	57	5
6	20	Dues, Fees, Subscriptions	Gross Billable Income	31	3,867,056	6,095	31,920	50	6
7	21	Clerical and General Office	Gross Billable Income	31	3,867,056	27,280	31,920	225	7
8	25	Other Admin. Staff Transport.	Gross Billable Income	31	3,867,056	11,773	31,920	97	8
9	26	Insurance	Gross Billable Income	31	3,867,056	14,568	31,920	120	9
10	30	Depreciation	Gross Billable Income	31	3,867,056	13,298	31,920	110	10
11	32	Interest	Gross Billable Income	31	3,867,056	40,850	31,920	337	11
12	33	Real Estate Taxes	Gross Billable Income	31	3,867,056		31,920		12
13	34	Rent - Building	Gross Billable Income	31	3,867,056	43,000	31,920	355	13
14	35	Rent - Equipment	Gross Billable Income	31	3,867,056	4,135	31,920	34	14
15	01	Dietary	Direct Billable Income	31	279,198	102,965	8,755	3,229	15
16	02	Food	Direct Billable Income	31	4,372	1,612			16
17	03	Housekeeping	Direct Billable Income	31					17
18	10	Nursing	Direct Billable Income	31					18
19	21	Clerical and General Office	Direct Billable Income	31					19
20	25	Other Admin. Staff Transport.	Direct Billable Income	31					20
21	39	Ancillary	Direct Billable Income	31	3,583,486	1,321,550	4,831	1,781	21
22	17	Administrative	Gross Billable Income	31	3,867,056	179,474	179,474	1,481	22
23	21	Clerical and General Office	Gross Billable Income	31	3,867,056	185,549	185,549	1,532	23
24	27	Employee Benefits	Gross Billable Income	31	3,867,056	49,573	31,920	409	24
25	TOTALS					\$ 2,134,357	\$ 365,023	\$ 10,855	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation		\$	\$		80	1
2	3	Housekeeping	Direct Allocation					42,066	2
3	4	Laundry	Direct Allocation					919	3
4	6	Repairs & Maintenance	Direct Allocation					17,844	4
5	10	Nursing	Direct Allocation					23,535	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	9
10	22	Employee Benefits	Direct Allocation					2,434	10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation					30,155	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				\$	\$		117,043	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 44,150	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				\$	\$		\$ 44,150	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning:

01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	06	Repairs	Direct Billing	669,310	26	\$ 79,460		\$	1
2	21	Office and Clerical	Direct Billing	669,310	26	8,933			2
3	25	Auto Expense / Travel	Direct Billing	669,310	26	473			3
4	26	Insurance	Direct Billing	669,310	26	1,630			4
5	30	Depreciation	Direct Billing	669,310	26	264,263			5
6	32	Interest	Direct Billing	669,310	26	44,568			6
7	30	Depreciation - Matrix	Patient Days	1,635,146	31	221,356	63,219	8,558	7
8	32	Interest - Matrix	Patient Days	1,635,146	31	51,456	63,219	1,989	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 672,138	\$	\$ 10,547	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning:

01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning:

01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Business Partners LLC		X	Mortgage			\$	10,187,169		\$	697,869	1								
2												2								
3												3								
4												4								
5	See Supplemental Schedule											5								
<b>Working Capital</b>																				
6	Diawa		X	Line of Credit				1,099,726			88,689	6								
7	Shareholder Loan	X		Line of Credit				507,574			5,933	7								
8	See Supplemental Schedule											8								
9	<b>TOTAL Facility Related</b>						\$	11,794,469		\$	792,491	9								
<b>B. Non-Facility Related*</b>																				
10	Allocated from CCI/ECC		X								39,878	10								
11	Allocated from CC/EC Clinical		X								7,389	11								
12	Allocated from CC Health Sys.		X								337	12								
13	See Supplemental Schedule										(3,944)	13								
14	<b>TOTAL Non-Facility Related</b>						\$			\$	43,660	14								
15	<b>TOTALS (line 9+line14)</b>						\$	11,794,469		\$	836,151	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ None                      Line # N/A

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	<b>TOTAL Long-Term</b>									7										
<b>Working Capital</b>																				
8										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	<b>TOTAL Working Capital</b>									14										
<b>B. Non-Facility Related*</b>																				
15	Allocated from Vent Lease		X							1,989	15									
16	Non-Allowable Interest									(5,933)	16									
17											17									
18											18									
19											19									
20	<b>TOTAL Non-Facility Related</b>									(3,944)	20									

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

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

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

B. Real Estate Taxes

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 report.	\$	<u>206,506</u>	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.)	\$	<u>199,747</u>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<u>(6,759)</u>	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<u>204,302</u>	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>	\$		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 \$ _____ For _____ 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.	\$	<u>197,543</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	<u>214,787</u>	8
	2004	<u>219,588</u>	9
	2005	<u>221,794</u>	10
	2006	<u>196,673</u>	11
	2007	<u>194,573</u>	12

2008 Accrual = \$194,573 x 1.05 = \$204,302

Allocated from CC/EC - \$4,958 CCI/ECC, \$216 CC/EC Clinical

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	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:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME 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 2007 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>14-05-402-027-0000</u>	<u>Long Term Care Property</u>	<u>\$ 97,286.72</u>	<u>\$ 97,286.72</u>
2. <u>14-05-402-028-0000</u>	<u>Long Term Care Property</u>	<u>\$ 97,286.72</u>	<u>\$ 97,286.72</u>
3. <u>See Attached</u>	<u>2201 Main, LLC Allocation</u>	<u>\$ 122,122.75</u>	<u>\$ 2,113.16</u>
4. <u>See Attached</u>	<u>Care Centers Building Allocation</u>	<u>\$ 43,667.89</u>	<u>\$ 1,125.40</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		<b>\$ 360,364.08</b>	<b>\$ 197,812.00</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? X YES        NO

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

**C. Tax Bills**

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME 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:

01/01/08 Ending:

12/31/08

**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>Allocated from CCI/ECC</u>			<u>15,806</u>	2
3	<b>TOTALS</b>			\$ <b>706,729</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	32,884	9
10	Various		1994		57,552		20	2,878	2,878	41,956	10
11	Various		1995		146,433		20	7,322	7,322	99,974	11
12	Various		1996		67,704		20	3,385	3,385	42,635	12
13	Various		1997		53,902		20	2,696	2,696	31,127	13
14	Various		1998		172,679		20	8,637	8,637	91,498	14
15	Various		1999		62,682		20	3,134	3,134	29,966	15
16	Various		2000		149,525		20	7,503	7,503	63,909	16
17	Various		2001		56,462		20	2,823	2,823	21,960	17
18	Various		2002		66,781		20	5,850	5,850	43,806	18
19	Various		2003		90,561		20	8,482	8,482	68,833	19
20	Various		2004		93,861		20	10,294	10,294	45,996	20
21											21
22											22
23											23
24											24
25											25
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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:

01/01/08

Ending:

12/31/08

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
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	192,245		115,269	(76,976)	461,076	67
68		88,157	4,660		4,660		38,894	68
69			161,632			(161,632)		69
70		\$ 5,595,428	\$ 358,537		\$ 185,078	\$ (173,459)	\$ 1,114,514	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:

01/01/08

Ending:

12/31/08

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 5,595,428	\$ 358,537		\$ 185,078	\$ (173,459)	\$ 1,114,514	1
2	Fire Alarm	2005	7,870		20	787	787	3,148	2
3	Reface Cabinets & Counter Tops	2005	3,600		20	720	720	2,820	3
4	Elevator Repair	2005	7,918		20	792	792	3,035	4
5	Hot Water System (Reclass From F&E)	2005	6,083		20	608	608	2,230	5
6	Leasehold Improvements	2005	2,656		20	266	266	885	6
7	Seco Refrigeration	2005	3,382		20	338	338	1,127	7
8	Anerson Elevator	2005	6,495		20	650	650	2,165	8
9	Parking Garage	2005	381,112		20	19,056	19,056	65,107	9
10	Additional Garage Costs	2005	53,203		20	2,660	2,660	8,202	10
11	Water Heater Repair	2005	2,674		20	134	134	435	11
12	Pump Repair	2005	1,859		20	93	93	294	12
13	Boiler Repair	2005	1,874		20	94	94	289	13
14	Curtains	2005	1,966		20	98	98	311	14
15	Rebuilt Circulating Pump	2005	2,106		20	105	105	492	15
16	Repair Air Conditioner	2005	583		20	29	29	136	16
17	Repair Hot Water Heater	2005	774		20	39	39	181	17
18	Repairs To Boiler & Roof Exhausts	2005	1,273		20	64	64	297	18
19	Motor Repairs	2005	1,035		20	52	52	242	19
20	Elevator Motor Repair	2005	279		20	14	14	119	20
21	Repairs To Hot Water Booster	2005	884		20	44	44	191	21
22	Repair Fire Sprinkler	2005	1,195		20	60	60	260	22
23	Repairs To Generator	2005	2,548		20	127	127	381	23
24	15Th Payment On Garage Work	2006	36,749		20	3,675	3,675	9,800	24
25	Painting-Labor Only	2006	14,000		20	1,400	1,400	3,617	25
26	1 Cookson Coiling Service Door & Sensor	2006	9,400		20	940	940	2,428	26
27	Ligat Architects-Consulting On Garage Repairs	2006	14,432		20	1,443	1,443	3,488	27
28	Byrne Johson Roofing	2006	4,350		20	435	435	1,015	28
29	Plumbing Repairs	2006	6,454		20	1,291	1,291	3,657	29
30	Parking Garage Repair	2006	29,553		20	2,955	2,955	6,403	30
31	Installation And Relocation Of Sprinkler Heads	2006	12,750		20	1,275	1,275	2,656	31
32	Spirnkler Repairs - Connect Canopy To Antifreeze Loop	2006	2,800		20	280	280	583	32
33	Install Smoke Detector In Elevator Shaft	2006	1,669		20	167	167	348	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,218,954	\$ 358,537		\$ 225,768	\$ (132,769)	\$ 1,240,856	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:

01/01/08

Ending:

12/31/08

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 6,218,954	\$ 358,537		\$ 225,768	\$ (132,769)	\$ 1,240,856	1
2	Automatic Transfer Switch	2006	2,563		20	256	256	534	2
3	Rebuilt House Pump #2	2006	3,406		20	341	341	710	3
4	Fire Sprinkler Modification	2006	16,645		20	1,665	1,665	3,745	4
5	Hot Water Tank, Valve, Piping Repairs	2007	7,406		20	741	741	1,358	5
6	Pump Repair	2007	2,672		20	267	267	468	6
7	Replace Leaking Sewer Lines	2007	12,861		20	1,286	1,286	2,144	7
8	Water Pump & Gasket, Generator Emer Srvc	2007	3,232		20	323	323	539	8
9	A/C Repair	2007	3,264		20	272	272	385	9
10	Sprinkler System Repair	2007	2,420		20	242	242	343	10
11	Generator Repairs	2007	3,161		20	452	452	602	11
12	Pipe Repairs In Ceiling Of Maint Rm	2007	2,500		20	250	250	333	12
13	Repaired & Replaced Pumps In Boiler Room	2007	3,012		20	301	301	326	13
14	Reclass - Recovering Of Awning	2007	2,950		20	590	590	639	14
15	Modernize Elevators	2008	249,785		20	12,489	12,489	12,489	15
16	Replace Air Filter;Radiator;Coolant & Coolant Disposal	2008	3,203		20	267	267	267	16
17	Replace Boiler And Hot Water Leaking Pipes	2008	2,835		20	197	197	197	17
18	3 Deluxe Pressure Guards	2008	3,719		20	310	310	310	18
19	New Power Lines For Washer & Dryer	2008	6,100		20	356	356	356	19
20	Repairs To Walk In Freezer	2008	3,108		20	155	155	155	20
21	Fire Safety Equipment	2008	3,306		20	83	83	83	21
22	Wiring For Wireless Matix Access	2008	8,162		20	272	272	272	22
23	Electrical Installation For Elevator Upgrade	2008	23,950		20	200	200	200	23
24	Repairs To Garage Door	2008	3,089		20	26	26	26	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>		\$ 6,592,303	\$ 358,537		\$ 247,109	\$ (111,428)	\$ 1,267,337	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:

01/01/08

Ending:

12/31/08

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 6,592,303	\$ 358,537		\$ 247,109	\$ (111,428)	\$ 1,267,337	1
2									2
3									3
4									4
5									5
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32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,592,303	\$ 358,537		\$ 247,109	\$ (111,428)	\$ 1,267,337	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:

01/01/08

Ending:

12/31/08

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 6,592,303	\$ 358,537		\$ 247,109	\$ (111,428)	\$ 1,267,337	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,592,303	\$ 358,537		\$ 247,109	\$ (111,428)	\$ 1,267,337	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:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 6,592,303	\$ 358,537		\$ 247,109	\$ (111,428)	\$ 1,267,337	1
2									2
3									3
4									4
5									5
6									6
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,592,303	\$ 358,537		\$ 247,109	\$ (111,428)	\$ 1,267,337	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:

01/01/08

Ending:

12/31/08

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12F, Carried Forward</b>		\$ 6,592,303	\$ 358,537		\$ 247,109	\$ (111,428)	\$ 1,267,337	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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32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,592,303	\$ 358,537		\$ 247,109	\$ (111,428)	\$ 1,267,337	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:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 6,592,303	\$ 358,537		\$ 247,109	\$ (111,428)	\$ 1,267,337	1
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4									4
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,592,303	\$ 358,537		\$ 247,109	\$ (111,428)	\$ 1,267,337	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:

01/01/08

Ending:

12/31/08

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12H, Carried Forward</b>		\$ 6,592,303	\$ 358,537		\$ 247,109	\$ (111,428)	\$ 1,267,337	1
2									2
3									3
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28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,592,303	\$ 358,537		\$ 247,109	\$ (111,428)	\$ 1,267,337	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:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 6,592,303	\$ 358,537		\$ 247,109	\$ (111,428)	\$ 1,267,337	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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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)		\$ 6,592,303	\$ 358,537		\$ 247,109	\$ (111,428)	\$ 1,267,337	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:

01/01/08

Ending:

12/31/08

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12J, Carried Forward</b>		\$ 6,592,303	\$ 358,537		\$ 247,109	\$ (111,428)	\$ 1,267,337	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
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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>		\$ 6,592,303	\$ 358,537		\$ 247,109	\$ (111,428)	\$ 1,267,337	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:

01/01/08

Ending:

12/31/08

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12K, Carried Forward</b>		\$ 6,592,303	\$ 358,537		\$ 247,109	\$ (111,428)	\$ 1,267,337	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
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22									22
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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>		\$ 6,592,303	\$ 358,537		\$ 247,109	\$ (111,428)	\$ 1,267,337	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:

01/01/08

Ending:

12/31/08

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12L, Carried Forward		\$ 6,592,303	\$ 358,537		\$ 247,109	\$ (111,428)	\$ 1,267,337	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)		\$ 6,592,303	\$ 358,537		\$ 247,109	\$ (111,428)	\$ 1,267,337	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:

01/01/08

Ending:

12/31/08

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12M, Carried Forward</b>		\$ 6,592,303	\$ 358,537		\$ 247,109	\$ (111,428)	\$ 1,267,337	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>		\$ 6,592,303	\$ 358,537		\$ 247,109	\$ (111,428)	\$ 1,267,337	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:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12N, Carried Forward		\$ 6,592,303	\$ 358,537		\$ 247,109	\$ (111,428)	\$ 1,267,337	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
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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)		\$ 6,592,303	\$ 358,537		\$ 247,109	\$ (111,428)	\$ 1,267,337	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12O, Carried Forward		\$ 6,592,303	\$ 358,537		\$ 247,109	\$ (111,428)	\$ 1,267,337	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)		\$ 6,592,303	\$ 358,537		\$ 247,109	\$ (111,428)	\$ 1,267,337	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:

01/01/08

Ending:

12/31/08

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12P, Carried Forward</b>	\$ 6,592,303	\$ 358,537		\$ 247,109	\$ (111,428)	\$ 1,267,337	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>	\$ 6,592,303	\$ 358,537		\$ 247,109	\$ (111,428)	\$ 1,267,337	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:

01/01/08 Ending:

12/31/08

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	191		2005	1977	\$ 4,394,436	\$	39	\$ 112,678	\$ 112,678	\$ 450,712	
5											
6											
7											
8											
	<b>Improvement Type**</b>										
9	Site Improvements		2005		51,819			2,591		10,364	
10											
11	Sheridan Shores Property, LLC Depreciation					192,245			(192,245)		
12											
13											
14											
15											
16											
17											
18											
19											
20											
21											
22											
23											
24											
25											
26											
27											
28											
29											
30											
31											
32											
33											
34											
35											
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:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
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	TOTAL (lines 4 thru 69)	\$	4,446,255	\$	192,245	\$	115,269	\$	(79,567)	\$	461,076	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		Allocated from EC/CC Clinical, Inc.	2002	2002	\$ 1,943	\$ 54	39	\$ 54		\$ 317	4
5		Allocated from CCI/ECC - CCI Building		1996	29,122	747	39	747		8,992	5
6		Allocated from CCI/Extended Care Consulting, LLC	2002	2002	17,570	451	39	451		2,834	6
7											7
8											8
		Improvement Type**									
9		Allocated from CCI/Extended Care Consulting, LLC		2002	14,514	1,326	20	1,326		6,645	9
10		Allocated from CCI/Extended Care Consulting, LLC		2003	17,104	1,563	20	1,563		7,831	10
11		Allocated from CCI/Extended Care Consulting, LLC		2005	850	90	20	90		216	11
12		Allocated from CCI/Extended Care Consulting, LLC		2007	177	9	20	9		21	12
13											13
14		Allocated from CCI/ECC- CCI Building		1996	491	-	20	-		8,992	14
15		Allocated from CCI/ECC- CCI Building		1997	2,796	90	20	90		1,421	15
16											16
17		Allocated from CC/EC Clinical, Inc.		2002	1,605	147	20	147		735	17
18		Allocated from CC/EC Clinical, Inc.		2003	1,891	173	20	173		866	18
19		Allocated from CC/EC Clinical, Inc.		2005	94	10	20	10		24	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:

01/01/08

Ending:

12/31/08

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
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>	\$	\$		\$	\$	\$	70
			88,157		4,660		4,660	
							38,894	

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: 01/01/08 Ending: 12/31/08

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,230,808	\$ 16,899	\$ 114,298	\$ 97,399	10	\$ 818,182	71
72	Current Year Purchases	7,463	28	893	865	10	921	72
73	Fully Depreciated Assets	118,899				10	118,899	73
74								74
75	TOTALS	\$ 1,357,170	\$ 16,927	\$ 115,191	\$ 98,264		\$ 938,002	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from CCC/EC Clinical	2008	\$ 2,782	\$ 556	\$ 556	\$	5	\$ 1,082	76
77		Allocated from CCI/ECC	2008	33,369	2,073	2,073		5	28,689	77
78		Allocated from CC Health Sys	2008	104	21	21		5	24	78
79										79
80	TOTALS			\$ 36,255	\$ 2,650	\$ 2,650	\$		\$ 29,795	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)	\$ 8,692,457	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 378,114	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 364,951	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (13,163)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,235,134	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	Allocated from CCI/ECC				3,767			5
6	Allocated from CC Health Sys.				355			6
7	<b>TOTAL</b>				\$ 4,122			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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 3,347 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	<b>TOTAL</b>		\$	\$	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	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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	\$		\$ 24,040	\$		\$ 24,040	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			10,404			10,404	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			21,635			21,635	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				61,061		61,061	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>					85	47,728		47,813	13
14	<b>TOTAL</b>			\$		\$ 56,164	\$ 108,789		\$ 164,953	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: 01/01/08

Ending:

12/31/08

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 742	\$ 202,670	1
2	Cash-Patient Deposits	43,883	43,883	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	652,309	856,611	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	95,549	95,549	6
7	Other Prepaid Expenses	3,819	3,819	7
8	Accounts Receivable (owners or related parties)	500	236,500	8
9	Other(specify): <u>See Attached Schedule</u>	81,633	71,633	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 878,435	\$ 1,510,665	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	1,876,634	1,928,453	15
16	Equipment, at Historical Cost	814,083	1,401,367	16
17	Accumulated Depreciation (book methods)	(1,714,120)	(2,559,973)	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	4,639,672	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 5,122,134	\$ 10,494,879	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 6,000,569	\$ 12,005,544	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 642,570	\$ 642,571	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	41,770	41,770	28
29	Short-Term Notes Payable	1,099,726	1,099,726	29
30	Accrued Salaries Payable	222,930	222,930	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,575	18,575	31
32	Accrued Real Estate Taxes(Sch.IX-B)		204,302	32
33	Accrued Interest Payable	123,254	180,896	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	5,016,120	350,431	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 7,164,945	\$ 2,761,201	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	507,574	507,574	39
40	Mortgage Payable		10,187,169	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 507,574	\$ 10,694,743	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 7,672,519	\$ 13,455,944	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,671,950)	\$ (1,450,400)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 6,000,569	\$ 12,005,544	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,507,900)	1
2	Restatements (describe):		2
3	Pension Expense	(1,834)	3
4	Rounding	(3)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,509,737)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(207,139)	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	44,926	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)	\$ (162,213)	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)	\$ (1,671,950)	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: 01/01/08Ending: 12/31/08**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,649,094	1
2	Discounts and Allowances for all Levels	(296,579)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,352,515	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	222,401	6
7	Oxygen	1,732	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 224,133	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	125	16
17	Sale of Drugs	60,323	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,340	19
20	Radiology and X-Ray	800	20
21	Other Medical Services	8,814	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 81,402	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	5,846	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 5,846	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,663,896	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,559,993	31
32	Health Care	2,667,903	32
33	General Administration	1,817,203	33
<b>B. Capital Expense</b>			
34	Ownership	1,555,475	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	165,601	35
36	Provider Participation Fee	104,860	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,871,035	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(207,139)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (207,139)	43

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

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

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

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

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

# 0040444

Report Period Beginning: 01/01/08

Ending:

12/31/08

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,086	2,188	\$ 73,119	\$ 33.42	1
2	Assistant Director of Nursing	433	518	15,811	30.52	2
3	Registered Nurses	15,251	18,108	467,672	25.83	3
4	Licensed Practical Nurses	26,113	31,272	748,273	23.93	4
5	CNAs & Orderlies	72,346	80,001	779,853	9.75	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,068	7,869	109,884	13.96	8
9	Activity Director	1,811	1,988	31,644	15.92	9
10	Activity Assistants	7,048	7,674	72,093	9.39	10
11	Social Service Workers	14,786	16,587	221,849	13.37	11
12	Dietician					12
13	Food Service Supervisor	2,032	2,163	40,613	18.78	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,279	5,771	59,383	10.29	15
16	Dishwashers	14,255	15,938	143,387	9.00	16
17	Maintenance Workers	13,702	15,455	203,306	13.15	17
18	Housekeepers	20,335	22,025	190,550	8.65	18
19	Laundry	6,984	7,776	79,198	10.18	19
20	Administrator	1,873	2,113	96,571	45.70	20
21	Assistant Administrator	832	840	26,078	31.05	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,471	7,311	97,025	13.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,150	2,574	40,311	15.66	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	220,855	248,171	\$ 3,496,620 *	\$ 14.09	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	325	\$ 14,577	01-03	35
36	Medical Director	Monthly	3,600	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,728	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	15,932	12-03	45
46	Other(specify)				46
47	Psychiatrist	Monthly	13,700	10	47
48	<u>See Attached - Care Centers Allocation</u>		6,283		48
49	TOTAL (lines 35 - 48)	325	\$ 56,820		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: 01/01/08

Ending: 12/31/08

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Corey J. Nigro	Administrator	0	\$ 96,571	Workers' Compensation Insurance	\$ 57,982	IDPH License Fee	\$ 663	
Nathan Langsner	Assist. Admin.	0	26,078	Unemployment Compensation Insurance	61,255	Advertising: Employee Recruitment	15,888	
				FICA Taxes	257,315	Health Care Worker Background Check	5,280	
				Employee Health Insurance	112,761	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Fees	3,448	
				City Payroll Tax	2,797	IL Council On LTC	2,267	
				Employee Physicals	6,685	IL Association of HC Facilities	2,256	
				Pension Expense	29,049	Dues & Subscriptions	1,982	
				Other Employee Welfare	11,567	See Supplemental Schedule	7,118	
				Holiday Expense	3,758	Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						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)		
					\$ 543,169			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
Description				Description				
Amount				Line #				
Amount				Amount				
Nathan Langsner - Management Fees								
\$ 50,000								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL				
				\$				
\$ 50,000								
C. Professional Services				G. Schedule of Travel and Seminar**				
Vendor/Payee				Description				
Type				Amount				
Amount				Amount				
Frost, Ruttenberg & Rothblatt				Out-of-State Travel				
Accounting				\$				
Prospect Resources								
Natural Gas Procurement								
500								
Care Centers, Inc.				In-State Travel				
Other Professional Fees								
138								
Extended Care Consulting								
Other Professional Fees								
38								
Allegiance				Seminar Expense				
Employee Compliance				20,568				
262				Allocated from CCI/ECC				
Unemployment Consult.				1,802				
1,684				Allocated from CC/EC Clinical				
Payroll Processing				206				
12,598								
ADP				Entertainment Expense				
Payroll Processing				( )				
1,050				(agree to Sch. V, line 24, col. 8)				
Paycor				TOTAL				
MDS Software				\$ 22,576				
3,445								
Care Centers, Inc.								
Home Office Expense								
161,192								
Extended Care Consulting								
Home Office Expense								
111,746								
See Supplemental Schedule								
49,853								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)								
\$ 356,456								

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

\*\*See instructions.

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

Report Period Beginning: 01/01/08 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 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
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. ILCLTC - \$9,092; IL Assoc. of HCF - \$2,256
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,967 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 104,860  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ Yes
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A 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