

Facility Name & ID Number Sheridan Health Care Center

0027680 Report Period Beginning: 01/01/09 Ending: 12/31/09

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	87	Skilled (SNF)	87	31,755	1
2		Skilled Pediatric (SNF/PED)			2
3	163	Intermediate (ICF)	163	59,495	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	250	TOTALS	250	91,250	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	265		6,490	6,755	8
9	SNF/PED					9
10	ICF	60,113	4,220	210	64,543	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	60,378	4,220	6,700	71,298	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.13%

D. How many bed-hold days during this year were paid by the Department? None (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)
Meals on Wheels, Adult Day Care

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

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

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

I. On what date did you start providing long term care at this location?
Date started 01/01/1982

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/01/1982 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 87 and days of care provided 6,406

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Sheridan Health Care Center # 0027680 Report Period Beginning: 01/01/09 Ending: 12/31/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	435,552	64,785	10,778	511,115		511,115		511,115		1
2	Food Purchase		432,640		432,640		432,640	(256)	432,384		2
3	Housekeeping	419,883	91,415		511,298		511,298		511,298		3
4	Laundry	148,776	44,669	1,962	195,407		195,407		195,407		4
5	Heat and Other Utilities			311,312	311,312		311,312	(755)	310,557		5
6	Maintenance	188,399	39,977	186,339	414,715		414,715	34,427	449,142		6
7	Other (specify):*										7
8	TOTAL General Services	1,192,610	673,486	510,391	2,376,487		2,376,487	33,416	2,409,903		8
	B. Health Care and Programs										
9	Medical Director			27,000	27,000		27,000		27,000		9
10	Nursing and Medical Records	3,904,763	200,384	10,138	4,115,285		4,115,285		4,115,285		10
10a	Therapy	149,811		14,351	164,162		164,162	2,715	166,877		10a
11	Activities	166,611	35,468	7,472	209,551		209,551		209,551		11
12	Social Services	224,057		5,136	229,193		229,193		229,193		12
13	CNA Training										13
14	Program Transportation			11,228	11,228		11,228		11,228		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,445,242	235,852	75,325	4,756,419		4,756,419	2,715	4,759,134		16
	C. General Administration										
17	Administrative	145,032		12,500	157,532		157,532	9,291	166,823		17
18	Directors Fees										18
19	Professional Services			100,092	100,092		100,092	(788)	99,304		19
20	Dues, Fees, Subscriptions & Promotions			114,195	114,195		114,195	(77,137)	37,058		20
21	Clerical & General Office Expenses	155,989	8,099	197,980	362,068		362,068	(82,248)	279,820		21
22	Employee Benefits & Payroll Taxes			1,032,700	1,032,700		1,032,700	(3,744)	1,028,956		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,934	8,934		8,934	(360)	8,574		24
25	Other Admin. Staff Transportation			525	525		525		525		25
26	Insurance-Prop.Liab.Malpractice			185,681	185,681		185,681		185,681		26
27	Other (specify):*							2,252	2,252		27
28	TOTAL General Administration	301,021	8,099	1,652,607	1,961,727		1,961,727	(152,734)	1,808,993		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,938,873	917,437	2,238,323	9,094,633		9,094,633	(116,603)	8,978,030		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Sheridan Health Care Center

#0027680

Report Period Beginning:

01/01/09

Ending:

12/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			283,456	283,456		283,456	180,577	464,033			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			206,837	206,837		206,837	(961)	205,876			32
33	Real Estate Taxes			224,428	224,428		224,428		224,428			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			24,263	24,263		24,263		24,263			35
36	Other (specify):*			150	150		150		150			36
37	TOTAL Ownership			739,134	739,134		739,134	179,616	918,750			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		564,017	502,092	1,066,109		1,066,109		1,066,109			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			505	505		505		505			41
42	Provider Participation Fee			136,875	136,875		136,875		136,875			42
43	Other (specify):*	56,545		152	56,697		56,697	(56,697)				43
44	TOTAL Special Cost Centers	56,545	564,017	639,624	1,260,186		1,260,186	(56,697)	1,203,489			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,995,418	1,481,454	3,617,081	11,093,953		11,093,953	6,316	11,100,269			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

Sheridan Health Care Center

ID# 0027680

Report Period Beginning: 01/01/09

Ending: 12/31/09

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Miscellaneous Income	\$ (25,116)	21	1
2	Bank Charges	(1,517)	21	2
3	Marketing	(1,989)	21	3
4	COPE Dues	(7,926)	20	4
5	Prior Period Legal Fees	(788)	19	5
6	Additional Repairs and Maintenance	41,867	06	6
7	Additional Rehab Expense	2,715	10a	7
8	Capitalized Repairs and Maintenance	(7,440)	06	8
9	Marketing Travel	(152)	43	9
10	Marketing Salaries	(56,545)	43	10
11	Out of State Seminar	(360)	24	11
12	Prior Period Adjustment	(4,779)	21	12
13	Non-Care Asset Depreciation	(801)	30	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(62,831)		49

Sheridan Health Care Center

ID# 0027680

Report Period Beginning: 01/01/09

Ending: 12/31/09

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sheridan Health Care Center# 0027680

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(256)											(256)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(755)											(755)	5
6	Maintenance	34,427											34,427	6
7	Other (specify):*													7
8	TOTAL General Services	33,416											33,416	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy	2,715											2,715	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	2,715											2,715	16
	C. General Administration													
17	Administrative			2,616	6,675								9,291	17
18	Directors Fees													18
19	Professional Services	(788)											(788)	19
20	Fees, Subscriptions & Promotions	(77,137)											(77,137)	20
21	Clerical & General Office Expenses	(82,248)											(82,248)	21
22	Employee Benefits & Payroll Taxes	(3,744)											(3,744)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(360)											(360)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*			1,378	874								2,252	27
28	TOTAL General Administration	(164,277)		3,994	7,549								(152,734)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(128,146)		3,994	7,549								(116,603)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sheridan Health Care Center# 0027680

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	180,577											180,577	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(961)											(961)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	179,616											179,616	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(56,697)											(56,697)	43
44	TOTAL Special Cost Centers	(56,697)											(56,697)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(5,227)		3,994	7,549								6,316	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

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		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17 SALARY - STAN ARON	\$	PRO HEALTH CARE, INC.	100.00%	\$ 15,116	\$	15,116	15
16	V	27 PAYROLL TAXES		PRO HEALTH CARE, INC.	100.00%	1,378		1,378	16
17	V								17
18	V	17 MANAGEMENT FEES	12,500	PRO HEALTH CARE, INC.	100.00%			(12,500)	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		\$ 12,500			\$ 16,494	\$ *	3,994	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	17 SALARY - RON SHABAT	\$	SHABAT & ASSOCIATES	100.00%	\$ 6,675	\$ 6,675	15
16	V	27 PAYROLL TAXES		SHABAT & ASSOCIATES	100.00%	874	874	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		\$			\$ 7,549	\$ * 7,549	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 Health Care Center

0027680

Report Period Beginning: 01/01/09

Ending: 12/31/09

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

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

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.

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 Health Care Center

0027680

Report Period Beginning:

01/01/09

Ending:

12/31/09

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Stan Aron	Owner	Administrative	23.31%	See Attached	20.00	36.30%	Alloc. Salary	\$ 15,116	17-07	1
2	Ron Shabat	Owner	Administrative	15.04%	See Attached	2.00	5.00%	Alloc. Mgmt Fee	6,675	17-07	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 21,791		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 Health Care Center

0027680

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center

0027680

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization PRO HEALTH CARE, INC. C/O FR&R
 Street Address 111 PFINGSTEN ROAD
 City / State / Zip Code DEERFIELD, IL 60015
 Phone Number (847) 236-1111
 Fax Number (847) 236-1155

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	17	SALARY - STAN ARON	AVG. HOURS WORKED 43	4	\$ 32,500	\$ 32,500	20	\$ 15,116	1
2	27	PAYROLL TAXES	AVG. HOURS WORKED 43	4	2,962		20	1,378	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 35,462	\$ 32,500		\$ 16,494	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center

0027680

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization SHABAT & ASSOCIATES
 Street Address 7514 N. SKOKIE BLVD.
 City / State / Zip Code SKOKIE, IL 60077
 Phone Number (847) 982-1195
 Fax Number (847) 982-0992

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	SALARY - RON SHABAT	AVG. HOURS WORKED 40	4	\$ 133,500	\$ 133,500	2	\$ 6,675	1
2	27	PAYROLL TAXES	AVG. HOURS WORKED 40	4	17,480		2	874	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				\$ 150,980	\$ 133,500		\$ 7,549	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center

0027680

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center

0027680

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center

0027680

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center

0027680

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center

0027680

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center

0027680 Report Period Beginning: 01/01/09 Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center

0027680

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Sheridan Health Care Center

0027680

Report Period Beginning:

01/01/09

Ending:

12/31/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6	7	8	9	10												
												Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
													YES	NO				Original	Balance			
	A. Directly Facility Related																					
	Long-Term																					
1	MB Financial Bank		X	Mortgage	\$19,140.00	08/01/05	\$ 2,439,763	\$ 2,161,977	10/05/10	7.0400	\$ 156,345	1										
2	Partner Distributions		X					57,200				2										
3												3										
4												4										
5	See Supplemental Schedule											5										
	Working Capital																					
6	MB Financial Bank		X	Line of Credit	Varies	7/10/94	1,700,000	1,054,000		5.0000	46,168	6										
7	Bridgeview Bank		X	Line of Credit	Varies	3/20/07	100,000	7,800	03/19/08	7.6500	3,056	7										
8	See Supplemental Schedule						129,500				1,267	8										
9	TOTAL Facility Related				\$19,140.00		\$ 4,369,263	\$ 3,280,977			\$ 206,836	9										
	B. Non-Facility Related*																					
10	Interest Income		X								(961)	10										
11												11										
12												12										
13	See Supplemental Schedule											13										
14	TOTAL Non-Facility Related						\$	\$			\$ (961)	14										
15	TOTALS (line 9+line14)						\$ 4,369,263	\$ 3,280,977			\$ 205,875	15										

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Sheridan Health Care Center

0027680

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

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

1	2	3	4	5	6		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
A. Directly Facility Related																		
Long-Term																		
1						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
6											6							
7	TOTAL Long-Term										7							
Working Capital																		
8	First Midwest	X	Line of Credit	Various	4/20/03	\$ 129,500	\$			\$ 1,267	8							
9											9							
10											10							
11											11							
12											12							
13											13							
14	TOTAL Working Capital										14							
B. Non-Facility Related*																		
15						\$	\$			\$	15							
16											16							
17											17							
18											18							
19											19							
20	TOTAL Non-Facility Related										20							

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

Facility Name & ID Number Sheridan Health Care Center

0027680

Report Period Beginning:

01/01/09

Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 83,793 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 4

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).

Adult Day Care - 760 Square Feet

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>50,091</u>	<u>1990</u>	<u>\$ 28,460</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	50,091		\$ 28,460	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	250	1990	1975	\$ 5,384,307	\$	35	\$ 153,837	\$ 153,837	\$ 3,063,922	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1980	5,655		20			5,655	9
10	Various		1981	13,906		20			13,906	10
11	Various		1982	1,171		20			1,171	11
12	Various		1983	17,000		20			16,819	12
13	Various		1984	36,737		20			36,737	13
14	Various		1985	135,882		20			135,840	14
15	Various		1986	63,852		20			63,019	15
16	Various		1987	60,439		20			60,094	16
17	Various		1988	24,257		20			23,967	17
18	Various		1989	102,083		20	937	937	101,934	18
19	Various		1990	84,998		20	4,161	4,161	83,703	19
20	Various		1991	10,496		20	526	526	9,876	20
21	Various		1992	18,109		20	889	889	15,716	21
22	Various		1993	39,981		20	1,999	1,999	33,334	22
23	Various		1994	123,996		20	6,203	6,203	96,630	23
24	Various		1995	157,007		20	7,851	7,851	115,975	24
25	Various		1996	210,423		20	10,523	10,523	140,810	25
26	Various		1997	97,938		20	4,898	4,898	61,669	26
27	Various		1998	76,538		20	3,828	3,828	43,102	27
28	Various		1999	232,757		20	11,332	11,332	117,650	28
29	Various		2000	88,771		20	4,411	4,411	42,684	29
30	Various		2001	147,900		20	7,704	7,704	65,504	30
31	Various		2002	156,984		20	11,173	11,173	117,714	31
32	Various		2003	478,213		20	47,136	47,136	319,677	32
33	Various		2004	276,659		20	28,721	28,721	162,436	33
34	Various		2005	89,346		20	8,680	8,680	43,833	34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12F & 12G)							67
68	Related Party Allocations (Pages 12H & 12I)							68
69	Financial Statement Depreciation			282,655		(282,655)		69
70	TOTAL (lines 4 thru 69)	\$ 8,135,405	\$ 282,655		\$ 314,809	\$ 32,154	\$ 4,993,377	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sheridan Health Care Center

0027680

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 8,135,405	\$ 282,655		\$ 314,809	\$ 32,154	\$ 4,993,377	1
2	Plumbing	2006	4,420		20	295	295	1,032	2
3	Shower	2006	1,860		20	124	124	434	3
4	Econocare-Carpet	2006	4,712		20	314	314	1,100	4
5	Ramp	2006	3,300		20	330	330	1,238	5
6	Plumbing	2006	1,612		20	108	108	376	6
7	Generator	2006	8,844		20	1,263	1,263	4,738	7
8	Pipe	2006	4,695		20	313	313	1,096	8
9	Pipe-Northwest Town	2006	3,006		20	201	201	702	9
10	Pipe	2006	3,912		20	261	261	913	10
11	Generator	2006	26,814		20	1,341	1,341	4,692	11
12	Cooling	2006	4,258		20	355	355	1,301	12
13	Cooling	2006	1,408		20	117	117	420	13
14	Cooling	2006	2,442		20	204	204	729	14
15	Chiller	2006	2,391		20	199	199	714	15
16	Doors	2006	604		20	30	30	106	16
17	Pipes	2006	2,348		20	157	157	548	17
18	Laundry Panel	2006	2,807		20	187	187	655	18
19	Northtown	2006			20				19
20	Northtown-A/C Repair	2006	2,054		20	137	137	479	20
21	Northtown	2006			20				21
22	A/C Repair	2006	3,211		20	161	161	575	22
23	Water Pump Repair	2006	3,323		20	166	166	512	23
24	West Passenger Elevator Repair	2006	2,889		20	289	289	987	24
25	Crash Rail	2007	3,396		20	227	227	566	25
26	Exhaust Fan	2007	2,982		20	199	199	497	26
27	Water Tank	2007	9,977		20	665	665	1,663	27
28	Wiring	2007	1,552		20	104	104	259	28
29	North Town Water Tank	2007	6,000		20	400	400	1,000	29
30	Doors	2007	1,175		20	59	59	152	30
31	Electric Work	2007	14,962		20	998	998	2,494	31
32	Carpeting	2007	4,500		20	643	643	1,607	32
33	Improvements	2007	35,896		20	2,394	2,394	5,984	33
34	TOTAL (lines 1 thru 33)		\$ 8,306,755	\$ 282,655		\$ 327,050	\$ 44,395	\$ 5,030,946	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 Health Care Center

0027680

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 8,306,755	\$ 282,655		\$ 327,050	\$ 44,395	\$ 5,030,946	1
2	Improvements	2007	1,133		20	76	76	189	2
3	Perf Plumbing	2007	2,856		20	191	191	476	3
4	Awning	2007	1,493		20	100	100	249	4
5	Plumbing	2007	3,107		20	207	207	518	5
6	Condensor Replacement	2007	1,380		20	276	276	690	6
7	Back Door	2007	950		20	63	63	158	7
8	Plumbing	2007	2,729		20	182	182	455	8
9	Walk-In Freezer & Cooler Repair	2007	3,753		20	375	375	844	9
10	Replace 2Nd Main Pump	2007	5,455		20	546	546	1,637	10
11	Plumbing Repair	2007	2,876		20	288	288	719	11
12	Hvac Repair	2007	2,617		20	262	262	698	12
13	Window Treatments	2007	8,355		20	418	418	1,010	13
14	Drapes	2007	3,607		20	180	180	466	14
15	Hucker Electric	2008	1,909		20	191	191	366	15
16	Boiler - Northtown	2008	17,600		20	1,467	1,467	2,811	16
17	Northtown Mechanical - Piping	2008	4,820		20	482	482	884	17
18	Braille Signs	2008	579		20	116	116	222	18
19	Door Handle	2008	860		20	172	172	344	19
20	Wood Blinds	2008	1,452		20	145	145	254	20
21	Braille Sign	2008	669		20	134	134	234	21
22	Rich Signs	2008	679		20	136	136	238	22
23	Wood Blinds	2008	1,418		20	142	142	236	23
24	Alarm Syst	2008	400		20	80	80	133	24
25	Braille Sign	2008	736		20	147	147	245	25
26	Lights	2008	3,196		20	639	639	1,119	26
27	Parking Lot - Sealcoating & Striping	2008	2,450		20	245	245	408	27
28	Wall Sconce	2008	525		20	105	105	171	28
29	Sheridan Road Sign Lighting	2008	3,914		20	783	783	1,272	29
30	Smoke Tower Receptacle And Street Lighting	2008	4,450		20	445	445	705	30
31	Receptacles	2008	1,393		20	139	139	221	31
32	Wireless Security Appliance	2008	2,815		20	282	282	457	32
33	Ground Condensing Unit	2008	4,010		20	802	802	1,136	33
34	TOTAL (lines 1 thru 33)		\$ 8,400,941	\$ 282,655		\$ 336,866	\$ 54,211	\$ 5,050,511	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 Health Care Center

0027680

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 8,400,941	\$ 282,655		\$ 336,866	\$ 54,211	\$ 5,050,511	1
2	1St Floor Water Leakage	2008	4,046		20	809	809	1,146	2
3	Senior Technologies - Wanderguard	2008	4,987		20	997	997	1,330	3
4	North Town - Replace 100 Ton Comp	2008	21,589		20	2,159	2,159	2,429	4
5	Freezer Compressor	2008	3,100		20	310	310	349	5
6	Freezer Refrigeration	2008	7,827		20	783	783	881	6
7	North Town Mechanical	2008	20,000		20	2,000	2,000	2,250	7
8	Main Water Heater	2008	2,704		20	541	541	631	8
9	Heat System - Add Glycol	2008	1,708		20	342	342	399	9
10	York Chiller - Add Glycol	2008	705		20	141	141	165	10
11	Universal Elevator Works	2008	6,475		20	648	648	755	11
12	2 Elevators	2008	3,500		20	350	350	379	12
13	Wanderguard	2008	3,880		20	776	776	841	13
14	North Town - Boiler	2008	3,872		20	387	387	419	14
15	Replace Freezer Refrigeration	2008	7,826		20	783	783	848	15
16	Repair Leak, Replace Main & Circulating Pumps	2009	4,387		20	126	126	126	16
17	Boiler Room Pump Repair	2009	6,306		20	526	526	526	17
18	Overhead Line On Elevator Hoistway	2009	6,475		20	594	594	594	18
19	Tile & Coving Installation In Foyer Area	2009	3,396		20	133	133	133	19
20	Replace T-Couple On Cleaver Brook Boiler	2009	2,883		20	240	240	240	20
21	Replace Domestic Water Piping	2009	4,261		20	355	355	355	21
22	Replace Compressor	2009	32,686		20	1,838	1,838	1,838	22
23	Compressor	2009	9,404		20	470	470	470	23
24	Hot Water Line	2009	2,511		20	146	146	146	24
25	Water Pipes	2009	4,260		20	355	355	355	25
26	Water Pipes	2009	4,080		20	238	238	238	26
27	Exterior Brick Work	2009	36,000		20	1,500	1,500	1,500	27
28	Roof Repairs	2009	4,960		20	207	207	207	28
29	Doors, Ramp & Decking	2009	20,165		20	638	638	638	29
30	Windows	2009	8,909		20	148	148	148	30
31	Roof Drains	2009	14,156		20	236	236	236	31
32	Ahu Bearings	2009	2,546		20	21	21	21	32
33	Cooling Tank	2009	4,355		20	36	36	36	33
34	TOTAL (lines 1 thru 33)		\$ 8,664,900	\$ 282,655		\$ 355,699	\$ 73,044	\$ 5,071,140	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 8,664,900	\$ 282,655		\$ 355,699	\$ 73,044	\$ 5,071,140	1
2	2009	2,601		20	22	22	22	2
3	2009	3,043		20	51	51	51	3
4	2009	4,008		20	67	67	67	4
5	2009	6,750		20	113	113	113	5
6	2009	3,720		20	310	310	310	6
7	2009	3,720		20	279	279	279	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		\$ 8,688,742	\$ 282,655		\$ 356,541	\$ 73,886	\$ 5,071,982	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	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12H & 12I lines 1 thru 33)		\$	\$		\$	\$	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 Health Care Center

0027680

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 997,890	\$	\$ 98,608	\$ 98,608	10	\$ 797,991	71
72	Current Year Purchases	59,431		5,926	5,926	10	5,926	72
73	Fully Depreciated Assets	729,001				10	729,001	73
74								74
75	TOTALS	\$ 1,786,322	\$	\$ 104,534	\$ 104,534		\$ 1,532,918	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	Facility	VAN	2008	\$ 15,461	\$	\$ 2,958	\$ 2,958	5	\$ 4,615	76
77										77
78										78
79										79
80	TOTALS			\$ 15,461	\$	\$ 2,958	\$ 2,958		\$ 4,615	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)	\$ 10,518,985	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 282,655	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 464,033	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 181,378	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,609,515	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	LAND - 1994	\$ 199,000	\$	\$	86
87	REMODEL STORAGE ROOM - 1999	4,000	233	3,983	87
88	REMODEL STORAGE RM - 1999	10,000	389	6,639	88
89	REMODEL STORAGE ROOM - 1999	4,300	167	2,831	89
90	DAYCARE CTR ARCHITEC - 2000	787	12	191	90
91	TOTALS	\$ 218,087	\$ 801	\$ 13,644	91

G. Construction-in-Progress

	Description	Cost	
92	Architecture Fees for Const.	\$ 3,439	92
93	Architecture Fees for Const.	24,065	93
94	Architecture Fees for Const.	7,990	94
95		\$ 35,494	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								5
6								6
7	TOTAL				\$			7

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 15,360 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	<u>Administrator</u>	<u>2008 Acura RL</u>	\$ <u>741.94</u>	\$ <u>8,903</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>741.94</u>	\$ <u>8,903</u>	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5	6	7	8		
			Staff		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	\$		\$	193,766	\$			\$	193,766	1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				24,397					24,397	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	39 - 03	hrs				265,073					265,073	4	
5	Physician Care		visits										5	
6	Dental Care		visits										6	
7	Work Related Program		hrs										7	
8	Habilitation		hrs										8	
9	Pharmacy	39 - 02	# of prescrpts						307,867			307,867	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Other (specify):												12	
13	Other (specify): See Supplemental						18,856		256,150			275,006	13	
14	TOTAL			\$		\$	502,092	\$	564,017	\$		1,066,109	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 Health Care Center# 0027680Report Period Beginning: 01/01/09Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 95,723	\$	1
2	Cash-Patient Deposits	89,680		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,861,885		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	2,000		5
6	Prepaid Insurance	109,186		6
7	Other Prepaid Expenses	12,389		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	12,445		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,183,308	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	227,460		13
14	Buildings, at Historical Cost	5,384,307		14
15	Leasehold Improvements, at Historical Cost	3,069,328		15
16	Equipment, at Historical Cost	1,931,367		16
17	Accumulated Depreciation (book methods)	(6,388,885)		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>	69,347		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,292,924	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,476,232	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,057,085	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	99,129		28
29	Short-Term Notes Payable	1,119,000		29
30	Accrued Salaries Payable	215,765		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	219,916		32
33	Accrued Interest Payable	15,809		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	2,677		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,729,381	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,161,977		40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,161,977	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,891,358	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,584,874	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,476,232	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,484,306	1
2	Restatements (describe):		2
3	Rounding	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,484,308	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	157,766	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	(57,200)	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)	\$ 100,566	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,584,874	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,922,085	1
2	Discounts and Allowances for all Levels	239,684	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,161,769	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	735,397	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 735,397	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	237,375	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	25,478	19
20	Radiology and X-Ray		20
21	Other Medical Services	60,844	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 323,697	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	961	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 961	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	29,895	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 29,895	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,251,719	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,376,487	31
32	Health Care	4,756,419	32
33	General Administration	1,961,727	33
B. Capital Expense			
34	Ownership	739,134	34
C. Ancillary Expense			
35	Special Cost Centers	1,123,311	35
36	Provider Participation Fee	136,875	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,093,953	40
41	Income before Income Taxes (line 30 minus line 40)**	157,766	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 157,766	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 Health Care Center**

0027680

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,834	1,834	\$ 77,055	\$ 42.01	1
2	Assistant Director of Nursing	2,309	2,309	66,905	28.98	2
3	Registered Nurses	13,973	15,911	512,396	32.20	3
4	Licensed Practical Nurses	40,764	47,165	1,343,643	28.49	4
5	CNAs & Orderlies	137,009	149,978	1,821,267	12.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	13,111	14,865	149,811	10.08	8
9	Activity Director					9
10	Activity Assistants	14,621	16,405	166,611	10.16	10
11	Social Service Workers	15,444	11,098	224,057	20.19	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	34,858	38,584	435,552	11.29	15
16	Dishwashers					16
17	Maintenance Workers	14,130	16,067	188,399	11.73	17
18	Housekeepers	34,057	37,670	419,883	11.15	18
19	Laundry	12,390	13,383	148,776	11.12	19
20	Administrator	2,080	2,344	105,603	45.05	20
21	Assistant Administrator	1,344	1,344	39,429	29.34	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,995	7,501	155,989	20.80	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	4,150	4,832	83,497	17.28	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,080	2,080	56,545	27.19	33
34	TOTAL (lines 1 - 33)	351,149	383,370	\$ 5,995,418 *	\$ 15.64	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 10,778	01-03	35
36	Medical Director	Monthly	27,000	09-03	36
37	Medical Records Consultant	Monthly	6,888	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,250	10-03	39
40	Physical Therapy Consultant	Monthly	351	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	7,472	11-03	44
45	Social Service Consultant	Monthly	5,136	12-03	45
46	Other(specify)				46
47	<u>Rehab Consultant</u>	Monthly	14,000	10a-03	47
48					48
49	TOTAL (lines 35 - 48)		\$ 74,875		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 Health Care Center**

0027680

Report Period Beginning: **01/01/09**

Ending: **12/31/09**

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	
Julia Stangel	Administrator	0	\$ 105,602	Workers' Compensation Insurance	\$ 142,905	IDPH License Fee	\$ 995	
Laura Holmstrom (Left 06/09)	Assistant Admin.	0	39,429	Unemployment Compensation Insurance	52,247	Advertising: Employee Recruitment	14,959	
				FICA Taxes	437,973	Health Care Worker Background Check		
				Employee Health Insurance	324,707	(Indicate # of checks performed <u>320</u>)	3,200	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		<u>IL Council On LTC</u>	11,847	
				Personnel Costs	21,994	Dues & Subscriptions	4,642	
				Other Employee Benefits	36,688	Licenses & Fees	1,416	
				Christmas Expense	12,441			
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 145,032					
B. Administrative - Other								
Description			Amount					
Management Fees - Pro Health Care			\$ 12,500					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 12,500					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Frost, Ruttenberg & Rothblatt	Accounting		\$ 48,632				Out-of-State Travel	\$
Lifecare Software	Computer Support		7,497					
Atech	Computer Support		1,589					
Paychex	Payroll Processing		15,299				In-State Travel	
Farnsworth Group	Architectural Planning		10,980					
Poulos, Inc.	Construction Planning		1,674					
Personnel Planners	Unemployment Tax Cons.		4,070					
See Attached	Legal Fees		10,351				Seminar Expense	8,574
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Entertainment Expense	()
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 100,092				(agree to Sch. V,	
							line 24, col. 8)	\$ 8,574

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Health Care Center# 0027680

Report Period Beginning:

01/01/09

Ending:

12/31/09**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ILCLTC - \$19,773
- (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. \$ 50,902 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. \$ 136,875
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? 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.