

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

0040444 Report Period Beginning: 01/01/09 Ending: 12/31/09

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	<u>61,842</u>	<u>1,054</u>	<u>1,981</u>	<u>64,877</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>61,842</u>	<u>1,054</u>	<u>1,981</u>	<u>64,877</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.06%

D. How many bed-hold days during this year were paid by the Department? 2,671 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 5/1/1993

J. Was the facility purchased or leased after January 1, 1978?
YES Date 5/1/1993 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 1,981

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

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

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/09 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	253,919	51,388	12,498	317,805		317,805	(1,634)	316,171		1
2	Food Purchase		289,155		289,155		289,155	663	289,818		2
3	Housekeeping	213,694	72,969		286,663		286,663	(5,923)	280,740		3
4	Laundry	84,836	26,694		111,530		111,530	(729)	110,801		4
5	Heat and Other Utilities			204,016	204,016		204,016	(11,625)	192,391		5
6	Maintenance	213,800	30	185,378	399,208		399,208	6,909	406,117		6
7	Other (specify):*							2,571	2,571		7
8	TOTAL General Services	766,249	440,236	401,892	1,608,377		1,608,377	(9,767)	1,598,610		8
	B. Health Care and Programs										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	2,351,404	88,214	11,296	2,450,914		2,450,914	(3,370)	2,447,544		10
10a	Therapy	109,413			109,413		109,413	2,168	111,581		10a
11	Activities	133,753	19,432		153,185		153,185		153,185		11
12	Social Services	205,364	3,567	15,067	223,998		223,998	11,664	235,662		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							7,615	7,615		15
16	TOTAL Health Care and Programs	2,799,934	111,213	29,963	2,941,110		2,941,110	18,077	2,959,187		16
	C. General Administration										
17	Administrative	135,735		65,200	200,935		200,935	66,315	267,250		17
18	Directors Fees										18
19	Professional Services			374,183	374,183		374,183	(252,302)	121,881		19
20	Dues, Fees, Subscriptions & Promotions			63,774	63,774		63,774	(6,352)	57,422		20
21	Clerical & General Office Expenses	92,441	33,587	261,027	387,055		387,055	38,167	425,222		21
22	Employee Benefits & Payroll Taxes			642,661	642,661		642,661	(10,014)	632,647		22
23	Inservice Training & Education										23
24	Travel and Seminar			10,594	10,594		10,594	1,899	12,493		24
25	Other Admin. Staff Transportation			533	533		533	564	1,097		25
26	Insurance-Prop.Liab.Malpractice			269,446	269,446		269,446	1,330	270,776		26
27	Other (specify):*							46,625	46,625		27
28	TOTAL General Administration	228,176	33,587	1,687,418	1,949,181		1,949,181	(113,768)	1,835,413		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,794,359	585,036	2,119,273	6,498,668		6,498,668	(105,459)	6,393,209		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	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			149,124	149,124		149,124	193,224	342,348			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			98,012	98,012		98,012	715,810	813,822			32
33	Real Estate Taxes			198,575	198,575		198,575	2,912	201,487			33
34	Rent-Facility & Grounds			1,104,782	1,104,782		1,104,782	(1,099,335)	5,447			34
35	Rent-Equipment & Vehicles			9,799	9,799		9,799	3,227	13,026			35
36	Other (specify):*											36
37	TOTAL Ownership			1,560,292	1,560,292		1,560,292	(184,162)	1,376,130			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		122,550	235,806	358,356		358,356	(4,082)	354,274			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			104,573	104,573		104,573		104,573			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		122,550	340,379	462,929		462,929	(4,082)	458,847			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,794,359	707,586	4,019,944	8,521,889		8,521,889	(293,704)	8,228,185			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,403)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(9,368)	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	(47)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(132)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6,112)	21		18
19	Entertainment				19
20	Contributions	(5,000)	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	(87,614)	21		24
25	Fund Raising, Advertising and Promotional	(3,717)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(50)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(192,548)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (306,991)		\$	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)	13,287		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 13,287		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (293,704)		37

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

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

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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Sheridan Shores Care & Rehab CtrID# 0040444Report Period Beginning: 01/01/09Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Telephone Rebate	\$ (12)	21	1
2	Miscellaneous Income	(500)	21	2
3	Jury Duty Income	(52)	10	3
4	Theft Loss	(114)	21	4
5	Account Collection Expense	(98)	21	5
6	Prior Period Nursing Expense	(38,206)	10	6
7	Prior Period Water Expense	(12,209)	05	7
8	Non-Allowable Interest	(4,500)	32	8
9	Non-Allowable Office Expense	(54,800)	21	9
10	Annual Report	(350)	20	10
11	Guardianship Expense	(953)	21	11
12	2010 Seminars	(190)	24	12
13	2009 Seminars- From 2008 Cost Report	729	24	13
14	Building Company Filing Fees	(250)	21	14
15	Building Company Replacement Tax	(50)	21	15
16	Building Company Amortization	(62,653)	31	16
17	Non-Allowable Legal	(11,945)	19	17
18	Capitalized R&M	(6,395)	06	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	(192,548)		49

Sheridan Shores Care & Rehab CtrID# 0040444Report Period Beginning: 01/01/09Ending: 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 Shores Care & Rehab Ctr# 0040444

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			319		5,540	(9)			(7,484)			(1,634)	1
2	Food Purchase	(47)		710									663	2
3	Housekeeping			663		73	(6,659)						(5,923)	3
4	Laundry						(729)						(729)	4
5	Heat and Other Utilities	(14,612)		2,718		174				95			(11,625)	5
6	Maintenance	(6,395)		4,218	10,334	22	(1,419)		76	73			6,909	6
7	Other (specify):*				1,768	803							2,571	7
8	TOTAL General Services	(21,054)		8,628	12,102	6,612	(8,816)		76	(7,316)			(9,767)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(38,390)				37,712	(2,692)						(3,370)	10
10a	Therapy					2,168							2,168	10a
11	Activities													11
12	Social Services					11,664							11,664	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					7,615							7,615	15
16	TOTAL Health Care and Programs	(38,390)				59,159	(2,692)						18,077	16
	C. General Administration													
17	Administrative			3,112	11,282	49,192				2,729			66,315	17
18	Directors Fees													18
19	Professional Services	(11,945)		(136,541)		(103,922)			4	102			(252,302)	19
20	Fees, Subscriptions & Promotions	(9,067)		2,663		10				42			(6,352)	20
21	Clerical & General Office Expenses	(150,553)	300	21,797	169,692	11,031			(17,403)	3,303			38,167	21
22	Employee Benefits & Payroll Taxes				(9,709)	(305)							(10,014)	22
23	Inservice Training & Education													23
24	Travel and Seminar	539		83		1,277							1,899	24
25	Other Admin. Staff Transportation			486						78			564	25
26	Insurance-Prop.Liab.Malpractice			1,069		63			4	194			1,330	26
27	Other (specify):*				36,888	8,546				1,191			46,625	27
28	TOTAL General Administration	(171,026)	300	(107,331)	208,153	(34,108)			(17,395)	7,639			(113,768)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(230,470)	300	(98,703)	220,255	31,663	(11,508)		(17,319)	323			(105,459)	29

STATE OF ILLINOIS

Summary B

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

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	(9,368)	181,372	5,448		1,206			14,367	199			193,224	30
31	Amortization of Pre-Op. & Org.	(62,653)	62,653											31
32	Interest	(4,500)	623,062	80,079		14,575			2,594				715,810	32
33	Real Estate Taxes			2,627		285							2,912	33
34	Rent-Facility & Grounds		(1,104,782)	4,556						891			(1,099,335)	34
35	Rent-Equipment & Vehicles			3,218						9			3,227	35
36	Other (specify):*													36
37	TOTAL Ownership	(76,521)	(237,695)	95,928		16,066			16,961	1,099			(184,162)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(2,620)		(770)	(692)			(4,082)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers						(2,620)		(770)	(692)			(4,082)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(306,991)	(237,395)	(2,775)	220,255	47,729	(14,128)		(1,128)	730			(293,704)	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		
				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 Rental Income	\$ 1,104,782	Sheridan Shores Property LLC	100.00%	\$		(1,104,782) 1
2	V	33 Real Estate Taxes	202,956	Sheridan Shores Property LLC	100.00%	202,956		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%	50		50 4
5	V	30 Depreciation		Sheridan Shores Property LLC	100.00%	181,372		181,372 5
6	V	31 Amortization		Sheridan Shores Property LLC	100.00%	62,653		62,653 6
7	V	32 Interest Expense		Sheridan Shores Property LLC	100.00%	623,062		623,062 7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,307,738			\$ 1,070,343	\$ *	(237,395) 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	01 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 319	\$	319	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	710		710	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	663		663	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	2,718		2,718	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	4,218		4,218	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	3,112		3,112	20
21	V	19 Professional Fees	150,001	Extended Care Consulting, LLC	100.00%	13,460		(136,541)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	2,663		2,663	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	21,797		21,797	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	83		83	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	486		486	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	1,069		1,069	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	5,448		5,448	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	80,079		80,079	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	2,627		2,627	29
30	V	34 Rent - Building		Extended Care Consulting, LLC	100.00%	4,556		4,556	30
31	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	3,218		3,218	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 150,001			\$ 147,226	\$ *	(2,775)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	06 Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	10,334	\$	10,334	15
16	V	06 Maintenance (Direct)		Extended Care Consulting, LLC	100.00%				16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,768		1,768	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%				18
19	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	11,282		11,282	19
20	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	169,692		169,692	20
21	V	21 Office and Clerical (Direct)	48,547	Extended Care Consulting, LLC	100.00%	48,547			21
22	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	29,034		29,034	22
23	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	7,854		7,854	23
24	V	22 Employee Benefits	9,709	Extended Care Consulting, LLC	100.00%			(9,709)	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		\$ 58,256			\$ 278,511	\$ *	220,255	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	03 Housekeeping	\$	Extended Care Clinical, LLC	100.00%	\$ 73	\$	73	15
16	V	05 Utilities		Extended Care Clinical, LLC	100.00%	174		174	16
17	V	06 Maintenance		Extended Care Clinical, LLC	100.00%	22		22	17
18	V	19 Professional Fees	105,436	Extended Care Clinical, LLC	100.00%	1,514		(103,922)	18
19	V	20 Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	10		10	19
20	V	21 Office & Clerical		Extended Care Clinical, LLC	100.00%	1,287		1,287	20
21	V	24 Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,277		1,277	21
22	V	26 Insurance		Extended Care Clinical, LLC	100.00%	63		63	22
23	V	30 Depreciation		Extended Care Clinical, LLC	100.00%	1,206		1,206	23
24	V	32 Interest		Extended Care Clinical, LLC	100.00%	14,575		14,575	24
25	V	33 Real Estate Taxes		Extended Care Clinical, LLC	100.00%	285		285	25
26	V	01 Dietary Salary		Extended Care Clinical, LLC	100.00%	5,540		5,540	26
27	V	07 Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	803		803	27
28	V	10 Nursing Salary	927	Extended Care Clinical, LLC	100.00%	38,639		37,712	28
29	V	10a Rehab Salary		Extended Care Clinical, LLC	100.00%	2,168		2,168	29
30	V	12 Social Service Salary	600	Extended Care Clinical, LLC	100.00%	12,264		11,664	30
31	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	7,615		7,615	31
32	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	49,192		49,192	32
33	V	21 Office Salary		Extended Care Clinical, LLC	100.00%	9,744		9,744	33
34	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	8,546		8,546	34
35	V	22 Employee Benefits	305	Extended Care Clinical, LLC	100.00%			(305)	35
36	V								36
37	V								37
38	V								38
39	Total		\$ 107,268			\$ 154,997	\$ *	47,729	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$ 99	Xcel Supply, LLC	100.00%	\$ 90	\$ (9)
16	V	3 Housekeeping	72,509	Xcel Supply, LLC	100.00%	65,850	(6,659)
17	V	4 Laundry	7,935	Xcel Supply, LLC	100.00%	7,207	(729)
18	V	6 Repairs & Maintenance	15,456	Xcel Supply, LLC	100.00%	14,036	(1,419)
19	V	10 Nursing	29,319	Xcel Supply, LLC	100.00%	26,626	(2,692)
20	V	11 Activities		Xcel Supply, LLC	100.00%		
21	V	12 Social Service		Xcel Supply, LLC	100.00%		
22	V	20 Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%		
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%		
24	V	22 Employee Benefits		Xcel Supply, LLC	100.00%		
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%		
26	V	39 Ancillary	28,534	Xcel Supply, LLC	100.00%	25,914	(2,620)
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 153,851			\$ 139,723	\$ * (14,128)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 62,957	\$ 62,957	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	62,957	CCS Employee Benefits Group	100.00%		(62,957)	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		\$ 62,957			\$ 62,957	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	06 Repairs	\$	Vent Lease, LLC.	100.00%	\$ 76	\$	76	15
16	V	19 Professional Fees		Vent Lease, LLC.	100.00%	4		4	16
17	V	21 Office and Clerical		Vent Lease, LLC.	100.00%	6		6	17
18	V	25 Auto Expense / Travel		Vent Lease, LLC.	100.00%				18
19	V	26 Insurance		Vent Lease, LLC.	100.00%	4		4	19
20	V	30 Depreciation		Vent Lease, LLC.	100.00%	197		197	20
21	V	32 Interest		Vent Lease, LLC.	100.00%	33		33	21
22	V	30 Depreciation - Matrix		Vent Lease, LLC.	100.00%	14,170		14,170	22
23	V	32 Interest - Matrix		Vent Lease, LLC.	100.00%	2,561		2,561	23
24	V	21 Office and Clerical	17,409	Vent Lease, LLC.	100.00%			(17,409)	24
25	V	39 Ancillary	770	Vent Lease, LLC.	100.00%			(770)	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		\$ 18,179			\$ 17,051	\$ *	(1,128)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 Dietary	\$	Care Centers Health Systems, Inc.	100.00%	\$ 1,257	\$ 1,257	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%	95	95	17
18	V	06 Maintenance		Care Centers Health Systems, Inc.	100.00%	73	73	18
19	V	19 Professional Fees		Care Centers Health Systems, Inc.	100.00%	102	102	19
20	V	20 Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	42	42	20
21	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	517	517	21
22	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	78	78	22
23	V	26 Insurance		Care Centers Health Systems, Inc.	100.00%	194	194	23
24	V	30 Depreciation		Care Centers Health Systems, Inc.	100.00%	199	199	24
25	V	32 Interest		Care Centers Health Systems, Inc.	100.00%			25
26	V	33 Real Estate Taxes		Care Centers Health Systems, Inc.	100.00%			26
27	V	34 Rent - Building		Care Centers Health Systems, Inc.	100.00%	891	891	27
28	V	35 Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	9	9	28
29	V	01 Dietary	14,549	Care Centers Health Systems, Inc.	100.00%	5,808	(8,741)	29
30	V	02 Food		Care Centers Health Systems, Inc.	100.00%			30
31	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%			31
32	V	10 Nursing		Care Centers Health Systems, Inc.	100.00%			32
33	V	22 Employee Benefits		Care Centers Health Systems, Inc.	100.00%			33
34	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%			34
35	V	39 Ancillary	1,152	Care Centers Health Systems, Inc.	100.00%	460	(692)	35
36	V	17 Administrative		Care Centers Health Systems, Inc.	100.00%	2,729	2,729	36
37	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	2,786	2,786	37
38	V	27 Employee Benefits		Care Centers Health Systems, Inc.	100.00%	1,191	1,191	38
39	Total		\$ 15,701			\$ 16,431	\$ * 730	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

Facility Name & ID Number

Sheridan Shores Care & Rehab Ctr

0040444

Report Period Beginning:

01/01/09

Ending:

12/31/09

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	29.79%	See Attached	1.41	4.70%	Mgmt Fees	\$ 5,200	17-3	1
2	Adam Vales	Relative	Clerical		See Attached	0.37	0.93%	Alloc. Salary	660	22-7	2
3	Mark Steinberg	Relative	Adminsitative		See Attached	2.59	4.70%	AI Fee/AI Sal	7,851	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 13,711		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:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

0040444

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	30	\$ 6,770	\$	64,877	\$ 319	1
2	02	Food	Patient Days	30	15,058		64,877	710	2
3	03	Housekeeping	Patient Days	30	14,059		64,877	663	3
4	05	Utilities	Patient Days	30	57,646		64,877	2,718	4
5	06	Maintenance	Patient Days	30	89,465		64,877	4,218	5
6	17	Administrative	Patient Days	30	66,000		64,877	3,112	6
7	19	Professional Fees	Patient Days	30	285,482		64,877	13,460	7
8	20	Dues and Subscriptions	Patient Days	30	56,488		64,877	2,663	8
9	21	Office and Clerical	Patient Days	30	462,313		64,877	21,797	9
10	24	Seminar and Travel	Patient Days	30	1,768		64,877	83	10
11	25	Other Staff Admin. Trans.	Patient Days	30	10,309		64,877	486	11
12	26	Insurance	Patient Days	30	22,668		64,877	1,069	12
13	30	Depreciation	Patient Days	30	115,549		64,877	5,448	13
14	32	Interest	Patient Days	30	1,698,489		64,877	80,079	14
15	33	Real Estate Taxes	Patient Days	30	55,709		64,877	2,627	15
16	34	Rent - Building	Patient Days	30	96,636		64,877	4,556	16
17	35	Rent - Equipment & Auto	Patient Days	30	68,244		64,877	3,218	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,122,653	\$		\$ 147,226	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

0040444

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	06	Maintenance (Pooled)	Patient Days	30	219,177	219,177	64,877	10,334	1
2	06	Maintenance (Direct)	Direct	30	82,905	82,905			2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	30	37,501		64,877	1,768	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct	30	8,464	8,464			4
5	17	Administrative (Pooled)	Patient Days	30	239,303	239,303	64,877	11,282	5
6	21	Office and Clerical (Pooled)	Patient Days	30	3,599,211	3,599,211	64,877	169,692	6
7	21	Office and Clerical (Direct)	Direct	30	654,174			48,547	7
8	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	30	615,819	615,819	64,877	29,034	8
9	27	Emp. Ben. - Gen. Admin. (Direct)	Direct	30	73,650	73,650	64,877	7,854	9
10	22	Employee Benefits							10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 5,530,203	\$ 4,838,529		\$ 278,511	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

0040444

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Extended Care Clinical LLC

Street Address

2201 West Main Street

City / State / Zip Code

Evanston, Illinois 60202

Phone Number

(847) 905-3000

Fax Number

(847) 905-3030

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	03	Housekeeping	Patient Days	30	\$ 1,549	\$	64,877	\$ 73	1
2	05	Utilities	Patient Days	30	3,693		64,877	174	2
3	06	Maintenance	Patient Days	30	477		64,877	22	3
4	19	Professional Fees	Patient Days	30	32,105		64,877	1,514	4
5	20	Dues and Subscriptions	Patient Days	30	213		64,877	10	5
6	21	Office & Clerical	Patient Days	30	27,296		64,877	1,287	6
7	24	Travel and Seminar	Patient Days	30	27,079		64,877	1,277	7
8	26	Insurance	Patient Days	30	1,342		64,877	63	8
9	30	Depreciation	Patient Days	30	25,586		64,877	1,206	9
10	32	Interest	Patient Days	30	309,136		64,877	14,575	10
11	33	Real Estate Taxes	Patient Days	30	6,053		64,877	285	11
12	01	Dietary Salary	Patient Days	30	117,506	117,506	64,877	5,540	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	30	17,040		64,877	803	13
14	10	Nursing Salary	Patient Days	30	799,889	799,889	64,877	37,712	14
15	10a	Rehab Salary	Patient Days	30	45,993	45,993	64,877	2,168	15
16	12	Social Service Salary	Patient Days	30	247,396	247,396	64,877	11,664	16
17	15	Emp. Ben. - Healthcare	Patient Days	30	158,537		64,877	7,475	17
18	17	Administration Salary	Patient Days	30	1,043,375	1,043,375	64,877	49,192	18
19	21	Office Salary	Patient Days	30	206,680	206,680	64,877	9,744	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	30	181,271		64,877	8,546	20
21	10	Nursing Salary	Direct Allocation		494,488	494,488	64,877	927	21
22	12	Social Service Salary	Direct Allocation		196,033	196,033		600	22
23	15	Emp. Ben. - Healthcare	Direct Allocation		82,560			140	23
24									24
25	TOTALS				\$ 4,025,296	\$ 3,151,360		\$ 154,997	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

0040444

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation		\$	\$		\$ 90	1
2	3	Housekeeping	Direct Allocation					65,850	2
3	4	Laundry	Direct Allocation					7,207	3
4	6	Repairs & Maintenance	Direct Allocation					14,036	4
5	10	Nursing	Direct Allocation					26,626	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation						10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation					25,914	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				\$	\$		\$ 139,723	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

0040444

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 62,957	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				\$	\$		\$ 62,957	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

0040444

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 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	821,185	26	\$ 80,807	\$ 770	\$ 76	1
2	19	Professional Fees	Direct Billing	821,185	26	4,427	770	4	2
3	21	Office and Clerical	Direct Billing	821,185	26	6,852	770	6	3
4	25	Auto Expense / Travel	Direct Billing	821,185	26	356	770		4
5	26	Insurance	Direct Billing	821,185	26	4,573	770	4	5
6	30	Depreciation	Direct Billing	821,185	26	218,810	770	197	6
7	32	Interest	Direct Billing	821,185	26	35,420	770	33	7
8	30	Depreciation - Matrix	Patient Days	1,376,056	30	300,546	64,877	14,170	8
9	32	Interest - Matrix	Patient Days	1,376,056	30	54,323	64,877	2,561	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 706,114	\$	\$ 17,051	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

0040444

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	01	Dietary	Gross Billable Income	3,421,940	26	72,652	59,184	1,257	1	
2	03	Housekeeping	Gross Billable Income	3,421,940	26		59,184		2	
3	05	Heat and Other Utilities	Gross Billable Income	3,421,940	26	5,507	59,184	95	3	
4	06	Maintenance	Gross Billable Income	3,421,940	26	4,211	59,184	73	4	
5	19	Professional Fees	Gross Billable Income	3,421,940	26	5,880	59,184	102	5	
6	20	Dues, Fees, Subscriptions	Gross Billable Income	3,421,940	26	2,401	59,184	42	6	
7	21	Clerical and General Office	Gross Billable Income	3,421,940	26	29,869	59,184	517	7	
8	25	Other Admin. Staff Transport.	Gross Billable Income	3,421,940	26	4,509	59,184	78	8	
9	26	Insurance	Gross Billable Income	3,421,940	26	11,210	59,184	194	9	
10	30	Depreciation	Gross Billable Income	3,421,940	26	11,528	59,184	199	10	
11	32	Interest	Gross Billable Income	3,421,940	26		59,184		11	
12	33	Real Estate Taxes	Gross Billable Income	3,421,940	26		59,184		12	
13	34	Rent - Building	Gross Billable Income	3,421,940	26	51,522	59,184	891	13	
14	35	Rent - Equipment	Gross Billable Income	3,421,940	26	547	59,184	9	14	
15	01	Dietary	Direct Billable Income	206,522	26	82,445	14,549	5,808	15	
16	02	Food	Direct Billable Income	2,784	26	1,111			16	
17	03	Housekeeping	Direct Billable Income		26				17	
18	10	Nursing	Direct Billable Income	5,466	26	2,182			18	
19	22	Employee Benefits	Direct Billable Income	411	26	164			19	
20	25	Other Admin. Staff Transport.	Direct Billable Income		26				20	
21	39	Ancillary	Direct Billable Income	3,206,757	26	1,280,152	1,152	460	21	
22	17	Administrative	Gross Billable Income	3,421,940	26	157,769	157,769	59,184	2,729	22
23	21	Clerical and General Office	Gross Billable Income	3,421,940	26	161,081	161,081	59,184	2,786	23
24	27	Employee Benefits	Gross Billable Income	3,421,940	26	68,860		59,184	1,191	24
25	TOTALS					\$ 1,953,599	\$ 318,850	\$ 16,431	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

0040444

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

0040444

Report Period Beginning:

01/01/09

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 Shores Care & Rehab Ctr

0040444

Report Period Beginning:

01/01/09

Ending:

12/31/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Business Partners LLC		X	Mortgage			\$	\$ 9,967,779		\$ 623,062	1								
2											2								
3											3								
4											4								
5	See Supplemental Schedule										5								
Working Capital																			
6	DIAWA		X	Line of Credit				793,966		93,512	6								
7	Shareholder Loan	X		Line of Credit				475,074		4,500	7								
8	See Supplemental Schedule										8								
9	TOTAL Facility Related					\$	\$ 11,236,819			\$ 721,074	9								
B. Non-Facility Related*																			
10	Allocated From EC Consulting		X							80,079	10								
11	Allocated From EC Clinical		X							14,575	11								
12	Allocated From Vent Lease		X							2,594	12								
13	See Supplemental Schedule									(4,500)	13								
14	TOTAL Non-Facility Related					\$	\$			\$ 92,748	14								
15	TOTALS (line 9+line14)					\$	\$ 11,236,819			\$ 813,822	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.)

Facility Name & ID Number

Sheridan Shores Care & Rehab Ctr

0040444

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		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							\$	\$			\$	1								
2												2								
3												3								
4												4								
5												5								
6												6								
7	TOTAL Long-Term											7								
	Working Capital																			
8							\$	\$			\$	8								
9												9								
10												10								
11												11								
12												12								
13												13								
14	TOTAL Working Capital											14								
	B. Non-Facility Related*																			
15	Non-Allowable Interest						\$	\$			\$ (4,500)	15								
16												16								
17												17								
18												18								
19												19								
20	TOTAL Non-Facility Related										(4,500)	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.)

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 EC Consulting 2201 Main/EC Clinical 2201 Main</u>			<u>17,303</u>	2
3	TOTALS			\$ 708,226	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				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1993	42,874		20	2,145	2,145	35,028	9
10	Various		1994	57,552		20	2,878	2,878	44,832	10
11	Various		1995	146,433		20	7,322	7,322	107,293	11
12	Various		1996	67,704		20	3,385	3,385	46,020	12
13	Various		1997	53,902		20	2,696	2,696	33,821	13
14	Various		1998	172,679		20	8,637	8,637	100,128	14
15	Various		1999	62,682		20	3,134	3,134	33,098	15
16	Various		2000	149,525		20	7,503	7,503	71,413	16
17	Various		2001	56,462		20	2,823	2,823	24,784	17
18	Various		2002	66,781		20	5,718	5,718	49,523	18
19	Various		2003	90,561		20	5,028	5,028	73,860	19
20	Various		2004	93,861		20	8,502	8,502	54,499	20
21	Various		2005	491,369		20	26,829	26,829	119,221	21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

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)	4,446,255	116,133		114,007	(2,126)	575,083	67
68	Related Party Allocations (Pages 12H & 12I)	68,462	4,677		4,677		28,483	68
69	Financial Statement Depreciation		122,870			(122,870)		69
70	TOTAL (lines 4 thru 69)	\$ 6,067,102	\$ 243,680		\$ 205,284	\$ (38,396)	\$ 1,397,086	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

Report Period Beginning:

01/01/09

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		\$ 6,067,102	\$ 243,680		\$ 205,284	\$ (38,396)	\$ 1,397,086	1
2	15Th Payment On Garage Work	2006	36,749		20	3,675	3,675	13,475	2
3	Painting-Labor Only	2006	14,000		20	1,400	1,400	5,017	3
4	1 Cookson Coiling Service Door & Sensor	2006	9,400		20	940	940	3,368	4
5	Ligat Architects-Consulting On Garage Repairs	2006	14,432		20	1,443	1,443	4,931	5
6	Byrne Johson Roofing	2006	4,350		20	435	435	1,450	6
7	Plumbing Repairs	2006	6,454		20	1,291	1,291	4,948	7
8	Parking Garage Repair	2006	29,553		20	2,955	2,955	9,358	8
9	Installation And Relocation Of Sprinkler Heads	2006	12,750		20	1,275	1,275	3,931	9
10	Spirnkler Repairs - Connect Canopy To Antifreeze Loop	2006	2,800		20	280	280	863	10
11	Install Smoke Detector In Elevator Shaft	2006	1,669		20	167	167	514	11
12	Automatic Transfer Switch	2006	2,563		20	256	256	790	12
13	Rebuilt House Pump #2	2006	3,406		20	341	341	1,050	13
14	Fire Spinkler Modification	2006	16,645		20	1,665	1,665	5,410	14
15	Hot Water Tank, Valve, Piping Repairs	2007	7,406		20	741	741	2,098	15
16	Pump Repair	2007	2,672		20	267	267	735	16
17	Replace Leaking Sewer Lines	2007	12,861		20	1,286	1,286	3,430	17
18	Water Pump & Gasket, Generator Emer Srvc	2007	3,232		20	323	323	862	18
19	A/C Repair	2007	3,264		20	272	272	657	19
20	Sprinkler System Repair	2007	2,420		20	242	242	585	20
21	Generator Repairs	2007	3,161		20	452	452	1,054	21
22	Pipe Repairs In Ceiling Of Maint Rm	2007	2,500		20	250	250	583	22
23	Repaired & Replaced Pumps In Boiler Room	2007	3,012		20	301	301	628	23
24	Reclass - Recovering Of Awning	2007	2,950		20	590	590	1,229	24
25	Modernize Elevators	2008	249,785		20	12,489	12,489	24,979	25
26	Replace Air Filter;Radiator;Coolant & Coolant Disposal	2008	3,203		20	320	320	587	26
27	Replace Boiler And Hot Water Leaking Pipes	2008	2,835		20	236	236	433	27
28	3 Deluxe Pressure Guards	2008	3,719		20	372	372	682	28
29	New Power Lines For Washer & Dryer	2008	6,100		20	610	610	966	29
30	Repairs To Walk In Freezer	2008	3,108		20	311	311	466	30
31	Fire Safety Equipment	2008	3,306		20	331	331	413	31
32	Wiring For Wireless Matix Access	2008	8,162		20	816	816	1,088	32
33	Electrical Installation For Elevator Upgrade	2008	23,950		20	2,395	2,395	2,595	33
34	TOTAL (lines 1 thru 33)		\$ 6,569,519	\$ 243,680		\$ 244,011	\$ 331	\$ 1,496,261	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,569,519	\$ 243,680		\$ 244,011	\$ 331	\$ 1,496,261	1
2	Repairs To Garage Door	2008	3,089		20	309	309	335	2
3	Elevator Feeder Upgrade	2009	5,600		20	560	560	560	3
4	W/I Freezer Repair	2009	3,271		20	600	600	600	4
5	Elevator Flooring	2009	16,376		20	1,501	1,501	1,501	5
6	Water Storage Tank	2009	6,355		20	847	847	847	6
7	Refrigeration Repairs	2009	4,673		20	545	545	545	7
8	Elevator Repairs	2009	2,833		20	142	142	142	8
9	A/C Wall Unit	2009	3,088		20	309	309	309	9
10	Ejector Pump Repair	2009	5,203		20	217	217	217	10
11	Refrigeration Repairs	2009	2,566		20	171	171	171	11
12	Masonry Inspection	2009	3,810		20	95	95	95	12
13	Roof Repair	2009	7,480		20	125	125	125	13
14	Water Pump Replacement	2009	6,395		20	320	320	320	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)		\$ 6,640,258	\$ 243,680		\$ 249,752	\$ 6,072	\$ 1,502,028	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		\$ 6,640,258	\$ 243,680		\$ 249,752	\$ 6,072	\$ 1,502,028
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 6,640,258	\$ 243,680		\$ 249,752	\$ 6,072	\$ 1,502,028

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		\$ 6,640,258	\$ 243,680		\$ 249,752	\$ 6,072	\$ 1,502,028	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)	\$ 6,640,258	\$ 243,680		\$ 249,752	\$ 6,072	\$ 1,502,028	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	191 Beds	1977	4,446,255	116,133	39	114,007	(2,126)	575,083	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	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 Continued		\$	\$		\$	\$	\$	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 (12F & 12G lines 1 thru 33)		\$ 4,446,255	\$ 116,133		\$ 114,007	\$ (2,126)	\$ 575,083	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated From Extended Care Consulting 2201 Main LLC	2002	21,478	551	39	551		4,016	3
4	Allocated From Extended Care Clinical 2201 Main LLC	2002	2,366	61	39	61		442	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From Extended Care Consulting	2007	217	4	20	4		25	9
10	Allocated From Extended Care Consulting	2009	130	6	20	6		7	10
11									11
12	Allocated From Extended Care Consulting 2201 Main LLC	2002	17,743	1,622	20	1,622		9,745	12
13	Allocated From Extended Care Consulting 2201 Main LLC	2003	20,909	1,911	20	1,911		11,484	13
14	Allocated From Extended Care Consulting 2201 Main LLC	2005	1,039	110	20	110		375	14
15	Allocated From Extended Care Consulting 2201 Main LLC	2009	187	9	20	9		9	15
16									16
17	Allocated From Extended Care Clinical 2201 Main LLC	2002	1,955	179	20	179		1,073	17
18	Allocated From Extended Care Clinical 2201 Main LLC	2003	2,303	211	20	211		1,265	18
19	Allocated From Extended Care Clinical 2201 Main LLC	2005	114	12	20	12		41	19
20	Allocated From Extended Care Clinical 2201 Main LLC	2009	21	1	20	1		1	20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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)	\$ 68,462	\$ 4,677		\$ 4,677	\$	\$ 28,483	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:

01/01/09

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	\$ 1,052,322	\$ 103,926	\$ 91,102	\$ (12,824)	10	\$ 723,265	71
72	Current Year Purchases	6,542	3,094	478	(2,616)	10	478	72
73	Fully Depreciated Assets	330,724				10	330,724	73
74								74
75	TOTALS	\$ 1,389,588	\$ 107,020	\$ 91,580	\$ (15,440)		\$ 1,054,467	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Alloc. From EC Consulting	2009	\$ 15,161	\$ 237	\$ 237	\$	5	\$ 14,450	76
77		Alloc. From EC Clinical	2009	3,389	678	678		5	1,996	77
78		Alloc. From EC Health Systems	2009	507	101	101		5	152	78
79										79
80	TOTALS			\$ 19,057	\$ 1,016	\$ 1,016	\$		\$ 16,598	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)	\$ 8,757,129	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 351,716	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 342,348	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (9,368)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,573,093	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	Engineering Work	\$ 11,633	92
93	Architecture Planning	6,402	93
94			94
95		\$ 18,035	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	<u>Allocated From Extended Care Consulting</u>			<u>4,556</u>			5
6	<u>Allocated From Extended Care Health Systems</u>			<u>891</u>			6
7	TOTAL			\$ <u>5,447</u>			7

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 6,498 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>Facility</u>	<u>Mazda</u>	\$ <u>544.00</u>	\$ <u>6,528</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>544.00</u>	\$ <u>6,528</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		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	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	\$		\$ 92,156	\$		\$ 92,156	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			25,258			25,258	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			97,048			97,048	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				83,971		83,971	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>					21,344	38,579		59,923	13
14	TOTAL			\$		\$ 235,806	\$ 122,550		\$ 358,356	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: 01/01/09Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,517	\$ 383,790	1
2	Cash-Patient Deposits	71,919	71,919	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	930,258	930,258	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	199,010	199,010	6
7	Other Prepaid Expenses	2,071	2,071	7
8	Accounts Receivable (owners or related parties)	500	236,500	8
9	Other(specify): <u>See Attached Schedule</u>	2,973	4,709,662	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,208,248	\$ 6,533,210	10
B. Long-Term Assets				
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	1,935,971	1,987,790	15
16	Equipment, at Historical Cost	836,673	1,423,957	16
17	Accumulated Depreciation (book methods)	(1,863,244)	(2,890,469)	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	4,577,019	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,054,937	\$ 10,183,657	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,263,185	\$ 16,716,867	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 638,965	\$ 638,965	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	48,018	48,018	28
29	Short-Term Notes Payable	793,966	793,966	29
30	Accrued Salaries Payable	304,373	304,373	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,859	14,859	31
32	Accrued Real Estate Taxes(Sch.IX-B)	206,352	206,352	32
33	Accrued Interest Payable	123,254	149,212	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	5,276,805	5,277,805	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,406,592	\$ 7,433,550	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	475,074	475,074	39
40	Mortgage Payable		9,967,779	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)	\$ 475,074	\$ 10,442,853	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,881,666	\$ 17,876,403	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,618,481)	\$ (1,159,536)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,263,185	\$ 16,716,867	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,671,950)	1
2	Restatements (describe):		2
3	Prior Year Dividends	32,500	3
4	Rounding Adjustment	7	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,639,443)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	20,962	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 20,962	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)	\$ (1,618,481)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr

0040444

Report Period Beginning: 01/01/09

Ending: 12/31/09

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,432,605	1
2	Discounts and Allowances for all Levels	(821,532)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,611,073	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	793,225	6
7	Oxygen	3,575	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 796,800	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	89,825	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,256	19
20	Radiology and X-Ray	1,280	20
21	Other Medical Services	34,053	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 134,414	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	564	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 564	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,542,851	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,608,377	31
32	Health Care	2,941,110	32
33	General Administration	1,949,181	33
B. Capital Expense			
34	Ownership	1,560,292	34
C. Ancillary Expense			
35	Special Cost Centers	358,356	35
36	Provider Participation Fee	104,573	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,521,889	40
41	Income before Income Taxes (line 30 minus line 40)**	20,962	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 20,962	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: **01/01/09**

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	1,951	2,136	\$ 77,308	\$ 36.19	1
2	Assistant Director of Nursing	1,993	2,169	68,219	31.45	2
3	Registered Nurses	14,600	16,185	441,186	27.26	3
4	Licensed Practical Nurses	31,843	35,077	843,945	24.06	4
5	CNAs & Orderlies	78,273	87,125	884,931	10.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,114	7,711	109,413	14.19	8
9	Activity Director	2,039	2,247	38,917	17.32	9
10	Activity Assistants	8,435	9,455	94,836	10.03	10
11	Social Service Workers	13,228	14,202	205,364	14.46	11
12	Dietician					12
13	Food Service Supervisor	1,959	2,131	40,273	18.90	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,032	4,648	52,440	11.28	15
16	Dishwashers	15,643	17,394	161,206	9.27	16
17	Maintenance Workers	14,225	15,984	213,800	13.38	17
18	Housekeepers	20,642	23,263	213,694	9.19	18
19	Laundry	7,075	7,718	84,836	10.99	19
20	Administrator	2,009	2,325	135,413	58.24	20
21	Assistant Administrator	40	40	322	8.05	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,403	7,275	92,441	12.71	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,834	2,148	35,815	16.67	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	233,338	259,233	\$ 3,794,359 *	\$ 14.64	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	277	\$ 12,498	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	2,769	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	14,467	12-03	45
46	Other(specify)				46
47	<u>Psychiatrist</u>	Monthly	7,600	10-03	47
48	<u>See Attached</u>		1,527		48
49	TOTAL (lines 35 - 48)	277	\$ 42,461		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Nathan Langsner</u>	<u>Administrator</u>	<u>0.00%</u>	<u>\$ 135,735</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 59,924</u>	<u>IDPH License Fee</u>	<u>\$ 1,327</u>	
				<u>Unemployment Compensation Insurance</u>	<u>35,111</u>	<u>Advertising: Employee Recruitment</u>	<u>24,273</u>	
				<u>FICA Taxes</u>	<u>282,356</u>	<u>Health Care Worker Background Check</u>	<u>2,131</u>	
				<u>Employee Health Insurance</u>	<u>202,975</u>	<u>(Indicate # of checks performed <u>96</u>)</u>		
				<u>Employee Meals</u>		<u>Patient Background Checks <u>139</u></u>	<u>1,392</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Dues & Subscriptions</u>	<u>23,360</u>	
				<u>Employee Physicals</u>	<u>4,461</u>	<u>Licenses, Inspections, Permits</u>	<u>2,224</u>	
				<u>Union Pension</u>	<u>33,644</u>	<u>Advertising & Promotions</u>	<u>3,717</u>	
				<u>Other Employee Welfare</u>	<u>7,590</u>	<u>Allocated From Ext. Care Consulting</u>	<u>2,663</u>	
				<u>Holiday Expense</u>	<u>3,158</u>	<u>See Supplemental Schedule</u>	<u>52</u>	
				<u>Chicago Employer Tax</u>	<u>3,428</u>	<u>Less: Public Relations Expense</u>	<u>()</u>	
						<u>Non-allowable advertising</u>	<u>(3,717)</u>	
						<u>Yellow page advertising</u>	<u>()</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 135,735	TOTAL (agree to Schedule V, line 22, col.8)	\$ 632,647	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 57,422	
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Nathan Langsner- Management Fees</u>			<u>\$ 60,000</u>				<u>Out-of-State Travel</u>	<u>\$</u>
<u>Eric Rothner- Management Fees</u>			<u>5,200</u>					
							<u>In-State Travel</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 65,200	TOTAL		\$	<u>Seminar Expense</u>	<u>11,133</u>
(Attach a copy of any management service agreement)							<u>Allocated From Ext. Care Consulting</u>	<u>83</u>
							<u>Allocated From Ext. Care Clinical</u>	<u>1,277</u>
							<u>Entertainment Expense</u>	<u>()</u>
							<u>(agree to Sch. V, line 24, col. 8)</u>	
C. Professional Services							TOTAL	\$ 12,493
Vendor/Payee	Type		Amount					
<u>Frost, Ruttenberg & Rothblatt</u>	<u>Accounting</u>		<u>\$ 19,600</u>					
<u>See Attached</u>	<u>Legal</u>		<u>52,810</u>					
<u>Personnel Planners</u>	<u>Unemployment Consult</u>		<u>2,500</u>					
<u>Extended Care Consulting</u>	<u>Home Office Expenses</u>		<u>150,001</u>					
<u>Extended Care Clinical</u>	<u>Home Office Expenses</u>		<u>105,436</u>					
<u>Pinnacle Consulting</u>	<u>Customer Satisfaction</u>		<u>1,372</u>					
<u>Chad Cournaya</u>	<u>Medicare Consultant</u>		<u>75</u>					
<u>Allegiance</u>	<u>Employee Compliance</u>		<u>55</u>					
<u>Global Compliance</u>	<u>Employee Compliance</u>		<u>60</u>					
<u>National Hotline Services</u>	<u>Employee Compliance</u>		<u>63</u>					
<u>DIAWA</u>	<u>Audit Fee on Line of Credit</u>		<u>8,362</u>					
<u>See Supplemental Schedule</u>			<u>33,849</u>					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 374,183					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	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 Shores Care & Rehab Ctr# 0040444

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 \$18,661; AL Assoc of HC \$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. \$ 6,208 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 104,573
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 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? 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
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (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.