FOR BHF USE

LL1

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

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0040444

Facility Name: Sheridan Shores Care & Rehab Ctr

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

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 06/04/1993

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Andrew B. Cutler
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	61,692	575	1,542	63,809	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	61,692	575	1,542	63,809	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.53%

D. How many bed-hold days during this year were paid by the Department?
2,874 (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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 05/01/1993

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/1993 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 63 and days of care provided 1,542

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	251,841	48,115	11,602	311,558		311,558	1,081	312,639			1
2	Food Purchase		305,641		305,641		305,641	435	306,076			2
3	Housekeeping	221,330	65,596		286,926		286,926	(3,205)	283,721			3
4	Laundry	87,636	17,098		104,734		104,734	(849)	103,885			4
5	Heat and Other Utilities			219,264	219,264		219,264	(1,716)	217,548			5
6	Maintenance	253,019	97	183,743	436,859		436,859	(28,083)	408,776			6
7	Other (specify):*							2,100	2,100			7
8	**TOTAL General Services**	813,826	436,547	414,609	1,664,982		1,664,982	(30,237)	1,634,745			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	2,335,601	66,105	50,239	2,451,945		2,451,945	28,036	2,479,981			10
10a	Therapy	121,406			121,406		121,406	4,563	125,969			10a
11	Activities	118,371	11,371		129,742		129,742		129,742			11
12	Social Services	252,782	6,614	16,161	275,557		275,557	3,265	278,822			12
13	CNA Training											13
14	Program Transportation			220	220		220		220			14
15	Other (specify):*							9,320	9,320			15
16	**TOTAL Health Care and Programs**	2,828,160	84,090	70,220	2,982,470		2,982,470	45,184	3,027,654			16
	C. General Administration											
17	Administrative	155,555		70,300	225,855		225,855	58,557	284,412			17
18	Directors Fees											18
19	Professional Services			369,478	369,478	(21,500)	347,978	(236,402)	111,576			19
20	Dues, Fees, Subscriptions & Promotions			38,255	38,255		38,255	(5,361)	32,894			20
21	Clerical & General Office Expenses	91,580	36,548	183,470	311,598		311,598	78,340	389,938			21
22	Employee Benefits & Payroll Taxes			680,200	680,200		680,200	(20,336)	659,864			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,404	9,404		9,404	1,922	11,326			24
25	Other Admin. Staff Transportation			3,964	3,964		3,964	843	4,807			25
26	Insurance-Prop.Liab.Malpractice			219,269	219,269		219,269	1,103	220,372			26
27	Other (specify):*							36,940	36,940			27
28	**TOTAL General Administration**	247,135	36,548	1,574,340	1,858,023	(21,500)	1,836,523	(84,394)	1,752,129			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,889,121	557,185	2,059,169	6,505,475	(21,500)	6,483,975	(69,447)	6,414,528			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr #0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			145,725	145,725		145,725	174,589	320,314			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			19,170	19,170		19,170	373,608	392,778			32
33	Real Estate Taxes			132,499	132,499	21,500	153,999	2,150	156,149			33
34	Rent-Facility & Grounds			1,104,782	1,104,782		1,104,782	(1,103,451)	1,331			34
35	Rent-Equipment & Vehicles			26,657	26,657		26,657	(7,082)	19,575			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,428,833	1,428,833	21,500	1,450,333	(560,186)	890,147			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		141,388	152,265	293,653		293,653	(2,774)	290,879			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):*			49,700	49,700		49,700	(49,700)				43
44	**TOTAL Special Cost Centers**		141,388	306,538	447,926		447,926	(52,474)	395,452			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,889,121	698,573	3,794,540	8,382,234		8,382,234	(682,106)	7,700,128			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	(3,201)	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	3,582	30		9
10	Interest and Other Investment Income	(11,238)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(27)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,543)	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	(69,086)	21		24
25	Fund Raising, Advertising and Promotional	(3,684)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(151,050)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (245,247)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 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)	(436,859)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (436,859)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (682,106)		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 Yes	2 No	3 Amount	4 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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Sheridan Shores Care & Rehab Ctr

ID# 0040444

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Clothing	$ (339)	10	1
2	Theft Loss	(262)	21	2
3	Account Collection Expense	(408)	21	3
4	Non-Allowable Interest	(4,475)	32	4
5	Capitalized R&M	(39,958)	06	5
6	Website Fee	(12)	21	6
7	Annual Report	(350)	20	7
8	Non-Allowable Legal	(63)	19	8
9	Additional Seminar- From 2009 Cost Report	190	24	9
10	Building Company Bank Charges	(76)	21	10
11	Building Company Filing Fees	(250)	20	11
12	Building Company Amortization	(55,347)	31	12
13	Non-Allowable Management Fee	(49,700)	43	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(151,050)		49

Sheridan Shores Care & Rehab Ctr

ID# 0040444

Report Period Beginning: 01/01/10

Ending: 12/31/10

	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:** 01/01/10 **Ending:** 12/31/10

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			166		4,904		(3,989)					1,081	1
2	Food Purchase	(27)		462									435	2
3	Housekeeping			593		65				(3,863)			(3,205)	3
4	Laundry									(849)			(849)	4
5	Heat and Other Utilities	(3,201)		1,347		138							(1,716)	5
6	Maintenance	(39,958)		3,871	8,304	137			(4)	(433)			(28,083)	6
7	Other (specify):*				1,413	687							2,100	7
8	**TOTAL General Services**	(43,186)		6,439	9,717	5,931		(3,989)	(4)	(5,145)			(30,237)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(339)				31,556				(3,181)			28,036	10
10a	Therapy					4,563							4,563	10a
11	Activities													11
12	Social Services					3,265							3,265	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					5,520	3,800						9,320	15
16	**TOTAL Health Care and Programs**	(339)				44,904	3,800			(3,181)			45,184	16
	C. General Administration													
17	Administrative			2,743	10,652	45,162							58,557	17
18	Directors Fees													18
19	Professional Services	(63)		(138,566)		(97,773)							(236,402)	19
20	Fees, Subscriptions & Promotions	(9,284)	250	3,478		195							(5,361)	20
21	Clerical & General Office Expenses	(75,387)	76	16,248	129,109	8,294							78,340	21
22	Employee Benefits & Payroll Taxes				(16,500)		(3,800)			(36)			(20,336)	22
23	Inservice Training & Education													23
24	Travel and Seminar	190		170		1,562							1,922	24
25	Other Admin. Staff Transportation			843									843	25
26	Insurance-Prop.Liab.Malpractice			925		178							1,103	26
27	Other (specify):*				29,705	7,235							36,940	27
28	**TOTAL General Administration**	(84,544)	326	(114,159)	152,966	(35,147)	(3,800)			(36)			(84,394)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(128,069)	326	(107,720)	162,683	15,688		(3,989)	(4)	(8,362)			(69,447)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	3,582	165,062	5,000		945							174,589	30
31	Amortization of Pre-Op. & Org.	(55,347)	55,347											31
32	Interest	(15,713)	361,754	9,543		18,024							373,608	32
33	Real Estate Taxes			1,937		213							2,150	33
34	Rent-Facility & Grounds		(1,104,782)	1,331									(1,103,451)	34
35	Rent-Equipment & Vehicles			2,387								(9,469)	(7,082)	35
36	Other (specify):*													36
37	TOTAL Ownership	(67,478)	(522,619)	20,198		19,182						(9,469)	(560,186)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(234)		(2,089)		(451)	(2,774)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(49,700)											(49,700)	43
44	TOTAL Special Cost Centers	(49,700)						(234)		(2,089)		(451)	(52,474)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(245,247)	(522,293)	(87,522)	162,683	34,870		(4,223)	(4)	(10,451)		(9,920)	(682,106)	45

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] YES [ ] NO

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 1,104,782	Sheridan Shores Property LLC	100.00%	$	$ (1,104,782)	1
2	V	21	Bank Charges		Sheridan Shores Property LLC	100.00%	76	76	2
3	V	20	Filing Fees		Sheridan Shores Property LLC	100.00%	250	250	3
4	V	30	Depreciation		Sheridan Shores Property LLC	100.00%	165,062	165,062	4
5	V	31	Amortization		Sheridan Shores Property LLC	100.00%	55,347	55,347	5
6	V	32	Interest		Sheridan Shores Property LLC	100.00%	361,754	361,754	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,104,782			$ 582,489	$ * (522,293)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Extended Care Consulting, LLC	100.00%	$ 166	$ 166	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	462	462	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	593	593	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,347	1,347	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	3,871	3,871	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	2,743	2,743	20
21	V	19	Professional Fees	150,001	Extended Care Consulting, LLC	100.00%	11,435	(138,566)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	3,478	3,478	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	16,248	16,248	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	170	170	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	843	843	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	925	925	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	5,000	5,000	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	9,543	9,543	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,937	1,937	29
30	V	34	Rent - Building		Extended Care Consulting, LLC	100.00%	1,331	1,331	30
31	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	2,387	2,387	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			$ 62,479	$ * (87,522)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	8,304	$ 8,304	15
16	V	06	Maintenance (Direct)	159	Extended Care Consulting, LLC	100.00%	159		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,388	1,388	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	25	25	18
19	V	12	Admission (Direct)		Extended Care Consulting, LLC	100.00%			19
20	V	15	Emp. Ben. - Nursing (Direct)		Extended Care Consulting, LLC	100.00%			20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	10,652	10,652	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	129,109	129,109	22
23	V	21	Office and Clerical (Direct)	40,557	Extended Care Consulting, LLC	100.00%	40,557		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	23,355	23,355	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	6,350	6,350	25
26	V	22	Employee Benefits	16,500	Extended Care Consulting, LLC	100.00%		(16,500)	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			$ 57,216			$ 219,899	$ * 162,683	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	03	Housekeeping	$	Extended Care Clinical, LLC	100.00%	$ 65	$ 65	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	138	138	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	137	137	17
18	V	19	Professional Fees	105,436	Extended Care Clinical, LLC	100.00%	7,663	(97,773)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	195	195	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	1,830	1,830	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,562	1,562	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	178	178	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	945	945	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	18,024	18,024	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	213	213	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	4,904	4,904	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	687	687	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	31,556	31,556	28
29	V	10a	Rehab Salary		Extended Care Clinical, LLC	100.00%	4,563	4,563	29
30	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	3,265	3,265	30
31	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	5,520	5,520	31
32	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	45,162	45,162	32
33	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	6,464	6,464	33
34	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	7,235	7,235	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 105,436			$ 140,306	$ * 34,870	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$	Extended Care Clinical, LLC	100.00%	$	$	15
16	V	07	Emp. Ben. - General		Extended Care Clinical, LLC	100.00%			16
17	V	10	Nursing Salary	28,809	Extended Care Clinical, LLC	100.00%	28,809		17
18	V	12	Social Service Salary	4,715	Extended Care Clinical, LLC	100.00%	4,715		18
19	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	3,800	3,800	19
20	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%			20
21	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%			21
22	V	22	Employee Benefits	3,800	Extended Care Clinical, LLC	100.00%		(3,800)	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			$ 37,324			$ 37,324	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary Supplies, Supplements	$ 8,980	Care Centers Health Systems, Inc.	100.00%	$ 4,991	$ (3,989)	15
16	V	10	Nursing Supplies		Care Centers Health Systems, Inc.	100.00%			16
17	V	39	Ancillary Expense	527	Care Centers Health Systems, Inc.	100.00%	293	(234)	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			$ 9,507			$ 5,284	$ * (4,223)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	R&M - Equipment	$ 46	Reliable Medical of the Midwest, LLC	100.00%	$ 42	$ (4)	15
16	V	10	Nursing Supplies		Reliable Medical of the Midwest, LLC	100.00%			16
17	V	39	Ancillary Expense		Reliable Medical of the Midwest, LLC	100.00%			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			$ 46			$ 42	$ * (4)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Xcel Supply, LLC	100.00%	$	$	15
16	V	3	Housekeeping	57,976	Xcel Supply, LLC	100.00%	54,112	(3,863)	16
17	V	4	Laundry	12,736	Xcel Supply, LLC	100.00%	11,888	(849)	17
18	V	6	Repairs & Maintenance	6,497	Xcel Supply, LLC	100.00%	6,064	(433)	18
19	V	10	Nursing	47,739	Xcel Supply, LLC	100.00%	44,558	(3,181)	19
20	V	11	Activities		Xcel Supply, LLC	100.00%			20
21	V	12	Social Service		Xcel Supply, LLC	100.00%			21
22	V	20	Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21	Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22	Employee Benefits	534	Xcel Supply, LLC	100.00%	498	(36)	24
25	V	24	Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39	Ancillary	31,342	Xcel Supply, LLC	100.00%	29,253	(2,089)	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			$ 156,824			$ 146,373	$ * (10,451)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 91,377	$ 91,377	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	91,377	CCS Employee Benefits Group	100.00%		(91,377)	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			$ 91,377			$ 91,377	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Matrix Leasing	$ 17,619	Vent Lease LLC	100.00%	$ 8,150	$ (9,469)	15
16	V	39	Ventilator Equipment	840	Vent Lease LLC	100.00%	389	(451)	16
17	V	39	Other Ancillary		Vent Lease LLC	100.00%			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			$ 18,459			$ 8,539	$ * (9,920)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	29.79%	See Attached	1.58	3.40%	Mgmt Fees	$ 10,300	17-3	1
2	Adam Vales	Relative	Clerical	0.00%	See Attached	0.48	1.20%	Alloc Sal	839	21-7	2
3	Mark Steinberg	Relative	Administrative	0.00%	See Attached	2.32	4.20%	Al Sal/Al Fee	6,746	17-7	3
4	G. Matt Silvers	Relative	Administrative	0.00%	See Attached	0.27	1.21%	Alloc Sal	932	17-7	4
5											5
6											6
7	Where applicable, the amounts reported on this page have adjusted from the actual costs to reflect only amounts anticipated to be considered allowable by the										7
8	IL Dept. of HFS.										8
9											9
10											10
11											11
12											12
13								TOTAL	$ 18,817		13

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

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

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X]

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,512,273	34	$ 3,931	$	63,809	$ 166	1
2	02	Food	Patient Days	1,512,273	34	10,940		63,809	462	2
3	03	Housekeeping	Patient Days	1,512,273	34	14,059		63,809	593	3
4	05	Utilities	Patient Days	1,512,273	34	31,923		63,809	1,347	4
5	06	Maintenance	Patient Days	1,512,273	34	91,744		63,809	3,871	5
6	17	Administrative	Patient Days	1,512,273	34	65,000		63,809	2,743	6
7	19	Professional Fees	Patient Days	1,512,273	34	271,007		63,809	11,435	7
8	20	Dues and Subscriptions	Patient Days	1,512,273	34	82,419		63,809	3,478	8
9	21	Office and Clerical	Patient Days	1,512,273	34	385,083		63,809	16,248	9
10	24	Seminar and Travel	Patient Days	1,512,273	34	4,022		63,809	170	10
11	25	Other Staff Admin. Trans.	Patient Days	1,512,273	34	19,982		63,809	843	11
12	26	Insurance	Patient Days	1,512,273	34	21,934		63,809	925	12
13	30	Depreciation	Patient Days	1,512,273	34	118,510		63,809	5,000	13
14	32	Interest	Patient Days	1,512,273	34	226,162		63,809	9,543	14
15	33	Real Estate Taxes	Patient Days	1,512,273	34	45,910		63,809	1,937	15
16	34	Rent - Building	Patient Days	1,512,273	34	31,555		63,809	1,331	16
17	35	Rent - Equipment & Auto	Patient Days	1,512,273	34	56,569		63,809	2,387	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,480,749	$		$ 62,479	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance (Pooled)	Patient Days	1,512,273	34	196,794	196,794	63,809	8,304	1
2	06	Maintenance (Direct)	Direct		34	32,478	32,478		159	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,512,273	34	32,885		63,809	1,388	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		34	3,607			25	4
5	12	Admission (Direct)	Direct		34	52,036	52,036			5
6	15	Emp. Ben. - Nursing (Direct)	Direct		34	5,270				6
7	17	Administrative (Pooled)	Patient Days	1,512,273	34	252,448	252,448	63,809	10,652	7
8	21	Office and Clerical (Pooled)	Patient Days	1,512,273	34	3,059,876	3,059,876	63,809	129,109	8
9	21	Office and Clerical (Direct)	Direct		34	771,063	771,063		40,557	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,512,273	34	553,505		63,809	23,355	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		34	94,865			6,350	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					$ 5,054,827	$ 4,364,695		$ 219,899	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	03	Housekeeping	Patient Days	1,512,273	34	$ 1,549	$	63,809	$ 65	1
2	05	Utilities	Patient Days	1,512,273	34	3,268		63,809	138	2
3	06	Maintenance	Patient Days	1,512,273	34	3,240		63,809	137	3
4	19	Professional Fees	Patient Days	1,512,273	34	181,624		63,809	7,663	4
5	20	Dues and Subscriptions	Patient Days	1,512,273	34	4,624		63,809	195	5
6	21	Office & Clerical	Patient Days	1,512,273	34	43,370		63,809	1,830	6
7	24	Travel and Seminar	Patient Days	1,512,273	34	37,025		63,809	1,562	7
8	26	Insurance	Patient Days	1,512,273	34	4,213		63,809	178	8
9	30	Depreciation	Patient Days	1,512,273	34	22,389		63,809	945	9
10	32	Interest	Patient Days	1,512,273	34	427,165		63,809	18,024	10
11	33	Real Estate Taxes	Patient Days	1,512,273	34	5,058		63,809	213	11
12	01	Dietary Salary	Patient Days	1,512,273	34	116,221	116,221	63,809	4,904	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	1,512,273	34	16,288		63,809	687	13
14	10	Nursing Salary	Patient Days	1,512,273	34	747,870	747,870	63,809	31,556	14
15	10a	Rehab Salary	Patient Days	1,512,273	34	108,151	108,151	63,809	4,563	15
16	12	Social Service Salary	Patient Days	1,512,273	34	77,377	77,377	63,809	3,265	16
17	15	Emp. Ben. - Healthcare	Patient Days	1,512,273	34	130,816		63,809	5,520	17
18	17	Administration Salary	Patient Days	1,512,273	34	1,070,339	1,070,339	63,809	45,162	18
19	21	Office Salary	Patient Days	1,512,273	34	153,206	153,206	63,809	6,464	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	1,512,273	34	171,480		63,809	7,235	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,325,274	$ 2,273,164		$ 140,306	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Direct Allocation			$ 15,960	$ 15,960		$	1
2	07	Emp. Ben. - General	Direct Allocation			1,662				2
3	10	Nursing Salary	Direct Allocation			495,330	495,330		28,809	3
4	12	Social Service Salary	Direct Allocation			274,597	274,597		4,715	4
5	15	Emp. Ben. - Healthcare	Direct Allocation			94,697			3,800	5
6	17	Administration Salary	Direct Allocation			82,389	82,389			6
7	27	Emp. Ben. - Gen. Admin.	Direct Allocation			10,053				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					$ 974,688	$ 868,276		$ 37,324	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary Supplies, Supplements	Direct Allocation			$	$		$ 4,991	1
2	10	Nursing Supplies	Direct Allocation							2
3	39	Ancillary Expense	Direct Allocation						293	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					$	$		$ 5,284	25

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] NO [ ]

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

Name of Related Organization: Reliable Medical of the Midwest, LLC
Street Address: 200 Howard Avenue
City / State / Zip Code: Des Plaines, Illinois 60018-5909
Phone Number: (847) 566-0800
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	R&M - Equipment	Direct Allocation			$	$		$ 42	1
2	10	Nursing Supplies	Direct Allocation							2
3	39	Ancillary Expense	Direct Allocation							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					$	$		$ 42	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation			$	$		$	1
2	3	Housekeeping	Direct Allocation						54,112	2
3	4	Laundry	Direct Allocation						11,888	3
4	6	Repairs & Maintenance	Direct Allocation						6,064	4
5	10	Nursing	Direct Allocation						44,558	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						498	10
11	24	Seminars & Education	Direct Allocation							11
12	39	Ancillary	Direct Allocation						29,253	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					$	$		$ 146,373	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation			$	$		$ 91,377	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					$	$		$ 91,377	25

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	35	Matrix Leasing	Direct Allocation			$	$		$ 8,150	1
2	39	Ventilator Equipment	Direct Allocation						389	2
3	39	Other Ancillary	Direct Allocation							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					$	$		$ 8,539	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Business Partners LLC		X	Mortgage			$	$ 9,631,928			$ 361,754	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	DIAWA		X	Line of Credit							14,695	6
7	Shareholder Loan	X		Line of Credit				300,000			4,475	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 9,931,928			$ 380,924	9
	B. Non-Facility Related*											
10	Interest Income		X								(11,238)	10
11	Non-Allowable Interest										(4,475)	11
12												12
13	See Supplemental Schedule										27,567	13
14	TOTAL Non-Facility Related						$	$			$ 11,854	14
15	TOTALS (line 9+line14)						$	$ 9,931,928			$ 392,778	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: 01/01/10 Ending: 12/31/10

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	Allocated From EC Consulting		X				$	$			$ 9,543	15
16	Allocated From EC Clinical		X								18,024	16
17												17
18												18
19												19
20	TOTAL Non-Facility Related										27,567	20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2009 report.	$ 206,352	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 167,443	2
3. Under or (over) accrual (line 2 minus line 1).	$ (38,909)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 173,558	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.	$ 21,500	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 156,149	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	221,794	8
2006	196,673	9
2007	194,573	10
2008	196,526	11
2009	165,293	12

2010 Accrual - #165,293 X 1.05 = $173,558
Allocated From EC Consulting: $1,937
Allocated From EC Clinical: $213

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sheridan Shores Care & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040444

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-05-402-027-0000	Long Term Care Property	$ 82,646.69	$ 82,646.69
2.	14-05-402-028-0000	Long Term Care Property	$ 82,646.69	$ 82,646.69
3.	See Attached	Allocation From 2201 Main	$ 116,500.56	$ 2,200.07
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 281,793.94	$ 167,493.45

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

IMPORTANT NOTICE

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

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

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

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

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sheridan Shores Care & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040444

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 690,923	1
2	Allocated From EC Consulting 2201 Main/EC Clinical 2201 Main			15,486	2
3	TOTALS			$ 706,409	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	42,874		20	2,144	2,144	37,171	9
10	Various			1994	57,552		20	2,878	2,878	47,709	10
11	Various			1995	146,433		20	7,322	7,322	114,617	11
12	Various			1996	67,704		20	3,385	3,385	49,405	12
13	Various			1997	53,902		20	2,695	2,695	36,517	13
14	Various			1998	172,679		20	8,634	8,634	108,762	14
15	Various			1999	62,682		20	3,134	3,134	36,233	15
16	Various			2000	149,525		20	7,489	7,489	78,900	16
17	Various			2001	56,462		20	2,823	2,823	27,606	17
18	Various			2002	66,781		20	5,582	5,582	55,102	18
19	Various			2003	90,560		20	5,028	5,028	78,891	19
20	Various			2004	93,862		20	7,787	7,787	62,285	20
21	Various			2005	446,038		20	23,902	23,902	133,868	21
22	Various			2006	105,189		20	11,164	11,164	48,733	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

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	
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)		4,446,256	116,133		114,007	(2,126)	689,090	67
68	Related Party Allocations (Pages 12H & 12I)		62,408	4,248		4,248		29,747	68
69	Financial Statement Depreciation			125,471			(125,471)		69
70	TOTAL (lines 4 thru 69)		$ 6,120,908	$ 245,852		$ 212,222	$ (33,630)	$ 1,634,634	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: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,120,908	$ 245,852		$ 212,222	$ (33,630)	$ 1,634,634	1
2	Hot Water Tank, Valve, Piping Repairs	2007	7,406		20	741	741	2,839	2
3	Pump Repair	2007	2,672		20	267	267	1,002	3
4	Replace Leaking Sewer Lines	2007	12,861		20	1,286	1,286	4,716	4
5	Water Pump & Gasket, Generator Emer Srvc	2007	3,232		20	323	323	1,185	5
6	A/C Repair	2007	3,264		20	272	272	929	6
7	Sprinkler System Repair	2007	2,420		20	242	242	827	7
8	Generator Repairs	2007	3,161		20	452	452	1,505	8
9	Pipe Repairs In Ceiling Of Maint Rm	2007	2,500		20	250	250	833	9
10	Repaired & Replaced Pumps In Boiler Room	2007	3,012		20	301	301	929	10
11	Reclass - Recovering Of Awning	2007	2,950		20	590	590	1,819	11
12	Replace Air Filter;Radiator;Coolant & Coolant Disposal	2008	3,203		20	320	320	908	12
13	Replace Boiler And Hot Water Leaking Pipes	2008	2,835		20	236	236	669	13
14	3 Deluxe Pressure Guards	2008	3,719		20	372	372	1,054	14
15	New Power Lines For Washer & Dryer	2008	6,100		20	610	610	1,576	15
16	Repairs To Walk In Freezer	2008	3,108		20	311	311	777	16
17	Fire Safety Equipment	2008	3,306		20	331	331	744	17
18	Wiring For Wireless Matix Access	2008	8,162		20	816	816	1,904	18
19	Electrical Installation For Elevator Upgrade	2008	23,950		20	2,395	2,395	4,990	19
20	Repairs To Garage Door	2008	3,089		20	309	309	644	20
21	Elevator Feeder Upgrade	2008	5,600		20	280	280	583	21
22	Freezer	2009	3,271		20	654	654	1,254	22
23	Elevator Repairs	2009	16,376		20	1,638	1,638	3,139	23
24	Water Storage Tank	2009	6,355		20	1,271	1,271	2,118	24
25	Refrigeration Repairs	2009	4,673		20	935	935	1,480	25
26	Elevator Repairs	2009	2,833		20	283	283	425	26
27	A/C Wall Unit	2009	3,088		20	618	618	926	27
28	Ejector Pump Repair	2009	5,203		20	520	520	737	28
29	Refrigeration Repairs	2009	2,566		20	513	513	684	29
30	Masonary Inspection	2009	3,810		20	381	381	476	30
31	Roof Repair	2009	7,480		20	748	748	873	31
32	Modernize Elevators	2009	249,785		20	12,489	12,489	13,530	32
33	Water Pump Replacement	2009	6,395		20	320	320	533	33
34	TOTAL (lines 1 thru 33)		$ 6,539,293	$ 245,852		$ 243,296	$ (2,556)	$ 1,691,241	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: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,539,293	$ 245,852		$ 243,296	$ (2,556)	$ 1,691,241	1
2	Replaced Burners In Heating Boiler	2010	2,500		20	250	250	250	2
3	Rebuild Brick Wall, Brick, Tuckpointing, Concrete, Lighting	2010	16,915		20	740	740	740	3
4	Replace Boiler Room Storage Tanks	2010	7,485		20	686	686	686	4
5	Install Doors In Masonry Walls, Replace Damaged Blocks	2010	4,031		20	269	269	269	5
6	Wall A/C Unit	2010	4,310		20	359	359	359	6
7	Fire Alarm System Devices	2010	4,481		20	187	187	187	7
8	Wiring For Generator	2010	6,307		20	210	210	210	8
9	Fire Suppression System	2010	3,006		20	25	25	25	9
10	Used Generator	2010	43,500		20	1,450	1,450	1,450	10
11	Repair Water Leak	2010	4,862		20	243	243	243	11
12	Replace Countertop Laminate On 5Th, 6Th, And 7Th Floor	2010	4,763		20	238	238	238	12
13	Masonry Repair	2010	14,280		20	714	714	714	13
14	Leak Repair In Kitchen Storage Room	2010	6,533		20	327	327	327	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)		$ 6,662,267	$ 245,852		$ 248,993	$ 3,141	$ 1,696,939	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: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,662,267	$ 245,852		$ 248,993	$ 3,141	$ 1,696,939	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)		$ 6,662,267	$ 245,852		$ 248,993	$ 3,141	$ 1,696,939	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: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 6,662,267	$ 245,852		$ 248,993	$ 3,141	$ 1,696,939	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)		$ 6,662,267	$ 245,852		$ 248,993	$ 3,141	$ 1,696,939	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: 01/01/10 Ending: 12/31/10

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	4,446,256	116,133	39	114,007	(2,126)	689,090	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.

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

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)		$ 4,446,256	$ 116,133		$ 114,007	$ (2,126)	$ 689,090	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: 01/01/10 Ending: 12/31/10

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	19,222	493	39	493		4,087	3
4	Allocated From Extended Care Clinical 2201 Main LLC	2002	2,118	54	39	54		450	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From Extended Care Consulting	2007	194	10	20	10		39	9
10	Allocated From Extended Care Consulting	2009	116	6	20	6		12	10
11	Allocated From Extended Care Consulting	2010	1,138	57	20	57		57	11
12									12
13	Allocated From Extended Care Consulting 2201 Main LLC	2002	15,879	1,451	20	1,451		10,172	13
14	Allocated From Extended Care Consulting 2201 Main LLC	2003	18,713	1,710	20	1,710		11,987	14
15	Allocated From Extended Care Consulting 2201 Main LLC	2005	930	99	20	99		434	15
16	Allocated From Extended Care Consulting 2201 Main LLC	2009	168	8	20	8		17	16
17									17
18	Allocated From Extended Care Clinical 2201 Main LLC	2002	1,749	160	20	160		1,121	18
19	Allocated From Extended Care Clinical 2201 Main LLC	2003	2,061	188	20	188		1,321	19
20	Allocated From Extended Care Clinical 2201 Main LLC	2005	102	11	20	11		48	20
21	Allocated From Extended Care Clinical 2201 Main LLC	2009	18	1	20	1		2	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.

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 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
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 62,408	$ 4,248		$ 4,248	$	$ 29,747	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: 01/01/10 Ending: 12/31/10

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	$ 971,906	$ 67,497	$ 69,934	$ 2,437	10	$ 709,594	71
72	Current Year Purchases	9,525	2,699	703	(1,996)	10	4,771	72
73	Fully Depreciated Assets	395,634				10	395,634	73
74								74
75	TOTALS	$ 1,377,065	$ 70,196	$ 70,637	$ 441		$ 1,109,999	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated From EC Consulting	2010	$ 13,568	$ 212	$ 212	$	5	$ 13,144	76
77		Allocated From EC Clinical	2010	2,358	472	472		5	1,101	77
78										78
79										79
80	TOTALS			$ 15,926	$ 684	$ 684	$		$ 14,245	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)	$ 8,761,667	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 316,732	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 320,314	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,582	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,821,182	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated From Extended Care Consulting				1,331			5
6								6
7	TOTAL				$ 1,331 **			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: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 13,047 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	Facility	Mazda	$ 544.00	$ 6,528	17
18					18
19					19
20					20
21	TOTAL		$ 544.00	$ 6,528	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	1	2	3	4	5	6	7	8	
	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	$		$ 29,258	$		$ 29,258	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			74,980			74,980	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			47,088			47,088	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				87,407		87,407	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					939	53,981		54,920	13
14	TOTAL			$		$ 152,265	$ 141,388		$ 293,653	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

STATE OF ILLINOIS

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/10 (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	$ 136,885	1
2	Cash-Patient Deposits	45,741	45,741	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	672,024	672,024	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	224,795	224,795	6
7	Other Prepaid Expenses	979	979	7
8	Accounts Receivable (owners or related parties)	77,426	313,426	8
9	Other(specify): See Attached Schedule	550,685	5,469,999	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,573,167	$ 6,863,849	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	1,966,695	2,018,514	15
16	Equipment, at Historical Cost	891,964	1,479,248	16
17	Accumulated Depreciation (book methods)	(2,008,969)	(3,201,256)	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): See Attached Schedule	4,145,537	4,521,672	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,995,227	$ 9,903,538	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,568,394	$ 16,767,387	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,322,735	$ 1,322,735	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	29,749	29,749	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	302,868	302,868	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,630	16,630	31
32	Accrued Real Estate Taxes(Sch.IX-B)	173,558	173,558	32
33	Accrued Interest Payable	123,254	169,407	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	5,988,202	5,988,202	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,956,996	$ 8,003,149	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	300,000	300,000	39
40	Mortgage Payable		9,631,928	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 300,000	$ 9,931,928	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,256,996	$ 17,935,077	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,688,602)	$ (1,167,690)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,568,394	$ 16,767,387	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,618,481)	1
2	Restatements (describe):		2
3	**Medicare Settlements**	470	3
4	**Rounding Adjustment**	7	4
5	**Due From Officers Adjustment**	(32,500)	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,650,504)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(38,098)	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)**	$ (38,098)	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)**	$ (1,688,602)	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: 01/01/10 Ending: 12/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,203,884	1
2	Discounts and Allowances for all Levels	(401,363)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,802,521	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	406,438	6
7	Oxygen	6,277	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 412,715	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	90,391	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,713	19
20	Radiology and X-Ray	640	20
21	Other Medical Services	16,230	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 116,974	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11,238	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11,238	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	688	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 688	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,344,136	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,664,982	31
32	Health Care	2,982,470	32
33	General Administration	1,858,023	33
	B. Capital Expense		
34	Ownership	1,428,833	34
	C. Ancillary Expense		
35	Special Cost Centers	343,353	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)***	$ 8,382,234	40
41	**Income before Income Taxes (line 30 minus line 40)****	(38,098)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (38,098)	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: 01/01/10 Ending: 12/31/10

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,966	2,164	$ 81,190	$ 37.52	1
2	Assistant Director of Nursing	2,086	2,211	77,489	35.05	2
3	Registered Nurses	10,054	10,870	287,583	26.46	3
4	Licensed Practical Nurses	37,069	40,474	952,475	23.53	4
5	CNAs & Orderlies	77,746	86,050	900,162	10.46	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,244	9,110	121,406	13.33	8
9	Activity Director	1,178	1,366	25,603	18.74	9
10	Activity Assistants	7,941	8,997	92,768	10.31	10
11	Social Service Workers	16,051	17,054	252,782	14.82	11
12	Dietician					12
13	Food Service Supervisor	1,942	2,112	39,903	18.89	13
14	Head Cook					14
15	Cook Helpers/Assistants	3,806	4,424	50,672	11.45	15
16	Dishwashers	15,065	16,926	161,266	9.53	16
17	Maintenance Workers	16,265	18,166	253,019	13.93	17
18	Housekeepers	21,454	23,519	221,330	9.41	18
19	Laundry	7,738	8,492	87,636	10.32	19
20	Administrator	3,706	3,930	155,555	39.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,985	6,935	91,580	13.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,864	2,197	36,702	16.71	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	240,160	264,997	$ 3,889,121 *	$ 14.68	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	226	$ 11,602	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	9,830	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	11,446	12-03	45
46	Other(specify)				46
47	Psychiatrist	Monthly	11,600	10-03	47
48	See Attached		33,524		48
49	TOTAL (lines 35 - 48)	226	$ 81,602		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

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

** See instructions.

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nathan Langsner	Administrator	0.00%	$ 104,371
Kayla Moore	Administrator	0.00%	51,184
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 155,555

B. Administrative - Other

Description	Amount
Nathan Langsner- Management Fees	$ 60,000
Eric Rothner- Management Fees	10,300
TOTAL (agree to Schedule V, line 17, col. 3)	$ 70,300
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	Unemployment Consult	$ 1,979
Extended Care Consulting	Home Office Expenses	150,001
Extended Care Clinical	Home Office Expenses	105,436
Frost, Ruttenberg & Rothblatt	Accounting	26,124
Paycor	Payroll Processing	18,239
E-Health Data Solutions	MDS Data Processing	3,182
AIS Assessment & Intelligence	MDS Consultant	1,758
IIT/Sourcetech	Computer Services	660
Vision Share	Computer Services	1,756
National Datacare Corporation	Resident Fund Processing	2,214
See Attached	Legal	21,947
See Supplemetal Schedule		36,182
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 369,478

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 71,603
Unemployment Compensation Insurance	39,173
FICA Taxes	296,081
Employee Health Insurance	178,920
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Holiday Expense	2,900
Other Employee Welfare	14,593
Pension Expense	45,472
Employee Physicals	8,154
Chicago Head Tax	2,968
TOTAL (agree to Schedule V, line 22, col.8)	$ 659,864

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,182
Advertising: Employee Recruitment	5,157
Health Care Worker Background Check	
(Indicate # of checks performed 41)	972
Patient Background Checks 165	1,886
Advertising & Promotions	3,684
Dues & Subscriptions	17,490
Licenses, Inspections, Permits	2,532
See Supplemental Schedule	3,675
Less: Public Relations Expense	( )
Non-allowable advertising	(3,684)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,894

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	9,594
Allocated From EC Consulting	170
Allocated From EC Clinical	1,562
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,326

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/10 Ending: 12/31/10

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								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
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:** 01/01/10 **Ending:** 12/31/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on LTC $16,375**

(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. $ **5,134** Line **10-02**

(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. $ 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.