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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0040444

Facility Name: Sheridan Shores Care

Address: 5838 North Sheridan (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: 06/04/93

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 01/01/11 to 12/31/11 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) Lisa M. Hanlon, C.P.A.
(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 # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	61,794	704	2,179	64,677	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	61,794	704	2,179	64,677	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.77%

D. How many bed-hold days during this year were paid by the Department?
2,367 (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 2,179

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	255,156	46,913	9,115	311,184		311,184	7,559	318,743			1
2	Food Purchase		306,588		306,588		306,588	291	306,879			2
3	Housekeeping	224,688	45,545		270,233		270,233	(2,072)	268,161			3
4	Laundry	88,256	14,463		102,719		102,719	(622)	102,097			4
5	Heat and Other Utilities			213,663	213,663		213,663	612	214,275			5
6	Maintenance	234,031	22	130,037	364,090		364,090	12,157	376,247			6
7	Other (specify):*							3,240	3,240			7
8	**TOTAL General Services**	802,131	413,531	352,815	1,568,477		1,568,477	21,164	1,589,641			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	2,367,188	68,006	31,611	2,466,805		2,466,805	44,090	2,510,895			10
10a	Therapy	117,079			117,079		117,079		117,079			10a
11	Activities	149,138	19,073		168,211		168,211		168,211			11
12	Social Services	308,365	9,229	17,834	335,428		335,428	7,791	343,219			12
13	CNA Training											13
14	Program Transportation			367	367		367		367			14
15	Other (specify):*							11,862	11,862			15
16	**TOTAL Health Care and Programs**	2,941,770	96,308	53,412	3,091,490		3,091,490	63,743	3,155,233			16
	C. General Administration											
17	Administrative	210,016		60,000	270,016		270,016	61,623	331,639			17
18	Directors Fees											18
19	Professional Services			491,540	491,540		491,540	(371,282)	120,258			19
20	Dues, Fees, Subscriptions & Promotions			43,144	43,144		43,144	(8,456)	34,688			20
21	Clerical & General Office Expenses	95,059	31,440	284,470	410,969		410,969	(30,961)	380,008			21
22	Employee Benefits & Payroll Taxes			679,911	679,911		679,911	(16,040)	663,871			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,175	4,175		4,175	2,590	6,765			24
25	Other Admin. Staff Transportation			3,097	3,097		3,097	565	3,662			25
26	Insurance-Prop.Liab.Malpractice			210,222	210,222		210,222	(157)	210,065			26
27	Other (specify):*							39,141	39,141			27
28	**TOTAL General Administration**	305,075	31,440	1,776,559	2,113,074		2,113,074	(322,976)	1,790,098			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,048,976	541,279	2,182,786	6,773,041		6,773,041	(238,069)	6,534,972			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 #0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			149,434	149,434		149,434	129,141	278,575			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,777	17,777		17,777	532,769	550,546			32
33	Real Estate Taxes			180,045	180,045		180,045	2,091	182,136			33
34	Rent-Facility & Grounds			1,104,782	1,104,782		1,104,782	(1,104,782)				34
35	Rent-Equipment & Vehicles			23,991	23,991		23,991	(1,739)	22,252			35
36	Other (specify):*											36
37	TOTAL Ownership			1,476,029	1,476,029		1,476,029	(442,520)	1,033,509			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		188,715	211,472	400,187		400,187	(3,972)	396,215			39
40	Barber and Beauty Shops			189	189		189		189			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			387,720	387,720		387,720		387,720			42
43	Other (specify):*			25,000	25,000		25,000	(25,000)				43
44	TOTAL Special Cost Centers		188,715	624,381	813,096		813,096	(28,972)	784,124			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,048,976	729,994	4,283,196	9,062,166		9,062,166	(709,562)	8,352,604			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 # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Reference	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	(801)	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	(324)	30		9
10	Interest and Other Investment Income	(7,254)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(33)	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	(200)	21		18
19	Entertainment				19
20	Contributions	(5,800)	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	(131,989)	21		24
25	Fund Raising, Advertising and Promotional	(6,519)	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	(146,255)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (299,175)		$	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)	(410,386)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (410,386)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (709,562)		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

Sheridan Shores Care

ID# 0040444

Report Period Beginning: 01/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Jury Duty Income	$ (499)	10	1
2	Patient Clothing	(4,934)	10	2
3	Theft Loss	(764)	21	3
4	Collection Expense	(2,488)	21	4
5	PPA - Office Expenses (Achieve)	(44,895)	21	5
6	PPA - Professional Services	(3,277)	19	6
7	Non-Allowable Legal & Annual Report	(3,646)	19	7
8	Annual Report	(350)	20	8
9	Building Co. - Bank Charges	(13)	21	9
10	Building Co. - Filing Fees	(250)	20	10
11	Building Co. - State Replacement Tax	(100)	21	11
12	Building Co. - Amortization Expense	(56,367)	31	12
13	Non-Allowable Interest	(2,250)	32	13
14	Insurance Refund	(1,413)	26	14
15	Non-Allowable Fees	(25,000)	43	15
16	Non-Allowable Fees	(10)	21	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**	(146,255)		49

Sheridan Shores Care

ID# 0040444

Report Period Beginning: 01/01/11

Ending: 12/31/11

	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 **#** 0040444 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary			337		9,420		(2,198)					7,559	1
2	Food Purchase	(33)		324									291	2
3	Housekeeping			682		123			(2,877)				(2,072)	3
4	Laundry								(622)				(622)	4
5	Heat and Other Utilities	(801)		1,198		215							612	5
6	Maintenance			3,438	9,100	44			(425)				12,157	6
7	Other (specify):*				1,654	1,586							3,240	7
8	**TOTAL General Services**	(834)		5,979	10,754	11,388		(2,198)	(3,924)				21,164	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(5,432)				52,565			(3,043)				44,090	10
10a	Therapy													10a
11	Activities													11
12	Social Services					7,791							7,791	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					10,160	1,702						11,862	15
16	**TOTAL Health Care and Programs**	(5,432)				70,516	1,702		(3,043)				63,743	16
	C. General Administration													
17	Administrative			3,592	12,230	45,801							61,623	17
18	Directors Fees													18
19	Professional Services	(6,923)		(289,314)		(75,045)							(371,282)	19
20	Fees, Subscriptions & Promotions	(12,919)	250	4,021		192							(8,456)	20
21	Clerical & General Office Expenses	(180,459)	113	14,895	125,015	9,475							(30,961)	21
22	Employee Benefits & Payroll Taxes				(14,175)		(1,702)		(163)				(16,040)	22
23	Inservice Training & Education													23
24	Travel and Seminar			222		2,368							2,590	24
25	Other Admin. Staff Transportation			565									565	25
26	Insurance-Prop.Liab.Malpractice	(1,413)		1,070		186							(157)	26
27	Other (specify):*				30,424	8,717							39,141	27
28	**TOTAL General Administration**	(201,714)	363	(264,949)	153,494	(8,306)	(1,702)		(163)				(322,976)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(207,980)	363	(258,970)	164,248	73,598		(2,198)	(7,130)				(238,069)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sheridan Shores Care # 0040444 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(324)	116,132	11,562		1,771							129,141	30
31	Amortization of Pre-Op. & Org.	(56,367)	56,367											31
32	Interest	(9,504)	531,877	9,834		562							532,769	32
33	Real Estate Taxes			1,773		318							2,091	33
34	Rent-Facility & Grounds		(1,104,782)										(1,104,782)	34
35	Rent-Equipment & Vehicles			4,382						(6,121)			(1,739)	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(66,195)	(400,406)	27,551		2,651				(6,121)			(442,520)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(1,618)	(1,779)	(554)		(21)	(3,972)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(25,000)											(25,000)	43
44	**TOTAL Special Cost Centers**	(25,000)						(1,618)	(1,779)	(554)		(21)	(28,972)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(299,175)	(400,043)	(231,419)	164,248	76,249		(3,817)	(8,908)	(6,675)		(21)	(709,562)	45

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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%	13	13	2
3	V	20	Filing Fees		Sheridan Shores Property LLC	100.00%	250	250	3
4	V	21	State Replacement Tax		Sheridan Shores Property LLC	100.00%	100	100	4
5	V	30	Depreciation Expense		Sheridan Shores Property LLC	100.00%	116,132	116,132	5
6	V	31	Amortization Expense		Sheridan Shores Property LLC	100.00%	56,367	56,367	6
7	V	32	Interest Expense		Sheridan Shores Property LLC	100.00%	531,877	531,877	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,104,782			$ 704,739	$ * (400,043)	14

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

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

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%	$ 337	$ 337	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	324	324	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	682	682	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,198	1,198	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	3,438	3,438	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	3,592	3,592	20
21	V	19	Professional Fees	298,938	Extended Care Consulting, LLC	100.00%	6,714	(289,314)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	4,021	4,021	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	14,895	14,895	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	222	222	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	565	565	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,070	1,070	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	11,562	11,562	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	9,834	9,834	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,773	1,773	29
30	V	34	Rent - Building		Extended Care Consulting, LLC	100.00%			30
31	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	4,382	4,382	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 298,938			$ 64,609	$ * (231,419)	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 # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

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%	9,100	$ 9,100	15
16	V	06	Maintenance (Direct)	155	Extended Care Consulting, LLC	100.00%	155		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,632	1,632	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	22	22	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%	12,230	12,230	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	125,015	125,015	22
23	V	21	Office and Clerical (Direct)	39,253	Extended Care Consulting, LLC	100.00%	39,253		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	23,615	23,615	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	6,809	6,809	25
26	V	22	Employee Benefits	14,175	Extended Care Consulting, LLC	100.00%		(14,175)	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			$ 53,583			$ 217,831	$ * 164,248	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 # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

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%	$ 123	$ 123	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	215	215	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	44	44	17
18	V	19	Professional Fees	98,855	Extended Care Clinical, LLC	100.00%	23,631	(75,045)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	192	192	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	3,492	3,492	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	2,368	2,368	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	186	186	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	1,771	1,771	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	562	562	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	318	318	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	9,420	9,420	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,586	1,586	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	52,565	52,565	28
29	V	10a	Rehab Salary		Extended Care Clinical, LLC	100.00%			29
30	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	7,791	7,791	30
31	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	10,160	10,160	31
32	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	45,801	45,801	32
33	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	5,983	5,983	33
34	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	8,717	8,717	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 98,855			$ 174,925	$ * 76,249	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 # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 / Medical Record Salary	12,783	Extended Care Clinical, LLC	100.00%	12,783		17
18	V	12	Social Service / Admission Salary	734	Extended Care Clinical, LLC	100.00%	734		18
19	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	1,702	1,702	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	1,702	Extended Care Clinical, LLC	100.00%		(1,702)	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			$ 15,219			$ 15,219	$ *	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 # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 4,587	Care Centers Health Systems, Inc.	100.00%	$ 2,389	$ (2,198)	15
16	V	2	Food		Care Centers Health Systems, Inc.	100.00%			16
17	V	10	Nursing Supplies		Care Centers Health Systems, Inc.	100.00%			17
18	V	39	Ancillary Expense	3,377	Care Centers Health Systems, Inc.	100.00%	1,759	(1,618)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 7,964			$ 4,147	$ * (3,817)	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 # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	47,462	Xcel Supply, LLC	100.00%	44,585	(2,877)	16
17	V	4	Laundry	10,258	Xcel Supply, LLC	100.00%	9,636	(622)	17
18	V	6	Repairs & Maintenance	7,016	Xcel Supply, LLC	100.00%	6,591	(425)	18
19	V	10	Nursing	50,188	Xcel Supply, LLC	100.00%	47,145	(3,043)	19
20	V	11	Activities		Xcel Supply, LLC	100.00%			20
21	V	21	Office And Clerical		Xcel Supply, LLC	100.00%			21
22	V	22	Employee Benefits	2,682	Xcel Supply, LLC	100.00%	2,520	(163)	22
23	V	30	Fixed Assets-Depreciation		Xcel Supply, LLC	100.00%			23
24	V	39	Ancillary	29,340	Xcel Supply, LLC	100.00%	27,562	(1,779)	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			$ 146,946			$ 138,038	$ * (8,908)	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 # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	39	Ventilator Equipment	840	Vent Lease LLC	100.00%	286	(554)	15
16	V	39	Other Ancillary		Vent Lease LLC	100.00%			16
17	V	35	Matrix Leasing	6,121	Vent Lease LLC	100.00%		(6,121)	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			$ 6,961			$ 286	$ * (6,675)	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 # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

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%	$ 94,437	$ 94,437	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	94,437	CCS Employee Benefits Group	100.00%		(94,437)	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			$ 94,437			$ 94,437	$ *	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 # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$	Reliable Medical of the Midwest, LLC	100.00%	$	$	15
16	V	10	Nursing Supplies		Reliable Medical of the Midwest, LLC	100.00%			16
17	V	39	Ancillary Expense	2,391	Reliable Medical of the Midwest, LLC	100.00%	2,370	(21)	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			$ 2,391			$ 2,370	$ * (21)	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 # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	GALE ROTHNER	15.957%	WHEATON CARE CENTER	WHEATON	SHERIDAN SHORES PROPERTY	EVANSTON	BUILDING CO.	1
2	ERIC ROTHNER GRANTOR TRUST	29.787%	AVENUE CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	EXTENDED CARE CONSULTING	EVANSTON	MANAGEMENT/BOOKKI	2
3	NATHAN & SHIRLEY ROTHNER FAMILY TR	54.255%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	EXTENDED CARE CLINICAL	EVANSTON	ADMINISTRATIVE	3
4			BOULEVARD CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	CARE CENTER HEALTH SYSTE	DES PLAINES	DIETARY & FOOD SUPPI	4
5			BRIAR PLACE, LTD.	INDIAN HEAD	CCS EMPLOYEE BENEFITS GR	EVANSTON	HEALTH INSURANCE	5
6			CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	XCEL MEDICAL SUPPLY	EVANSTON	MEDICAL SUPPLIES	6
7			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	VENTLEASE, LLC	EVANSTON	VENTILATOR RENTAL	7
8			DYER NURSING & REHAB	DYER, IN	2201 MAIN, LLC	EVANSTON	BLDG COMPANY	8
9			GRASMERE PLACE, LLC	CHICAGO	RELIABLE MEDICAL SUPPLY C	DES PLAINES	MEDICAL SUPPLIES	9
10			HILLCREST NURSING AND REHABILITATION CENTER,LLC	JOLIET				10
11			HOMESTEAD NURSING & REHAB	LINCOLN, NE				11
12			GOLDEN PLAINES	HITCHINSON, KS				12
13			LAKE COUNTY NURSING & REHAB	EAST CHICAGO, IN				13
14			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD				14
15			LANCASTER MANOR	LINCOLN, NE				15
16			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT				16
17			MCKINLEY HEALTH CARE CENTER	CANTON, OH				17
18			OAK PARK HEALTHCARE CENTER, L.L.C.	OAK PARK				18
19			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				19
20			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				20
21			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				21
22			RAINBOW BEACH QOC, L.L.C.	CHICAGO				22
23			SEBOS NURSING & REHAB	HOLBART, IN				23
24			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				24
25			SNOW VALLEY NURSING AND REHABILITATION CENTER, L.L.C.	LISLE				25
26			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				26
27			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				27
28								28
29								29
30								30

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	G. Matt Silvers	Relative	Administrative	0.00%	See Attached	0.47	1.18%	Alloc Salary	$ 1,843	17-7	1
2	Adam Vales	Relative	Clerical	0.00%	See Attached	0.69	1.73%	Alloc Salary	1,232	22-7	2
3	Mark Steinberg	Relative	Administrative	0.00%	See Attached	4.26	4.85%	Al Sal/Al Fee	13,942	17-7	3
4											4
5											5
6											6
7											7
8											8
9	Where applicable, the amounts reported on this page have adjusted from the actual costs to reflect										9
10	only amounts anticipated to be considered allowable by the IL Dept. of HFS.										10
11											11
12											12
13								TOTAL	$ 17,017		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 # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	1,332,501	31	$ 6,942	$	64,677	$ 337	1
2	02	Food	Patient Days	1,332,501	31	6,677		64,677	324	2
3	03	Housekeeping	Patient Days	1,332,501	31	14,059		64,677	682	3
4	05	Utilities	Patient Days	1,332,501	31	24,674		64,677	1,198	4
5	06	Maintenance	Patient Days	1,332,501	31	70,833		64,677	3,438	5
6	17	Administrative	Patient Days	1,332,501	31	74,000		64,677	3,592	6
7	19	Professional Fees	Patient Days	1,332,501	31	138,332		64,677	6,714	7
8	20	Dues and Subscriptions	Patient Days	1,332,501	31	82,842		64,677	4,021	8
9	21	Office and Clerical	Patient Days	1,332,501	31	306,863		64,677	14,895	9
10	24	Seminar and Travel	Patient Days	1,332,501	31	4,580		64,677	222	10
11	25	Other Staff Admin. Trans.	Patient Days	1,332,501	31	11,637		64,677	565	11
12	26	Insurance	Patient Days	1,332,501	31	22,043		64,677	1,070	12
13	30	Depreciation	Patient Days	1,332,501	31	238,204		64,677	11,562	13
14	32	Interest	Patient Days	1,332,501	31	202,602		64,677	9,834	14
15	33	Real Estate Taxes	Patient Days	1,332,501	31	36,524		64,677	1,773	15
16	34	Rent - Building	Patient Days	1,332,501	31			64,677		16
17	35	Rent - Equipment & Auto	Patient Days	1,332,501	31	90,286		64,677	4,382	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,331,096	$		$ 64,609	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	1,332,501	31	187,474	187,474	64,677	9,100	1
2	06	Maintenance (Direct)	Direct		31	122,603	122,603		155	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,332,501	31	33,619		64,677	1,632	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	16,441			22	4
5	12	Admission (Direct)	Direct		31					5
6	15	Emp. Ben. - Nursing (Direct)	Direct		31					6
7	17	Administrative (Pooled)	Patient Days	1,332,501	31	251,959	251,959	64,677	12,230	7
8	21	Office and Clerical (Pooled)	Patient Days	1,332,501	31	2,575,611	2,575,611	64,677	125,015	8
9	21	Office and Clerical (Direct)	Direct		31	545,076	545,076		39,253	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,332,501	31	486,522		64,677	23,615	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	78,893			6,809	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					$ 4,298,198	$ 3,682,723		$ 217,831	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	817,528	19	$ 1,549	$	64,677	$ 123	1
2	05	Utilities	Patient Days	817,528	19	2,718		64,677	215	2
3	06	Maintenance	Patient Days	817,528	19	557		64,677	44	3
4	19	Professional Fees	Patient Days	817,528	19	298,695		64,677	23,631	4
5	20	Dues and Subscriptions	Patient Days	817,528	19	2,426		64,677	192	5
6	21	Office & Clerical	Patient Days	817,528	19	44,146		64,677	3,492	6
7	24	Travel and Seminar	Patient Days	817,528	19	29,934		64,677	2,368	7
8	26	Insurance	Patient Days	817,528	19	2,346		64,677	186	8
9	30	Depreciation	Patient Days	817,528	19	22,389		64,677	1,771	9
10	32	Interest	Patient Days	817,528	19	7,100		64,677	562	10
11	33	Real Estate Taxes	Patient Days	817,528	19	4,024		64,677	318	11
12	01	Dietary Salary	Patient Days	817,528	19	119,073	119,073	64,677	9,420	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	817,528	19	20,044		64,677	1,586	13
14	10	Nursing Salary	Patient Days	817,528	19	664,429	664,429	64,677	52,565	14
15	10a	Rehab Salary	Patient Days	817,528	19			64,677		15
16	12	Social Service Salary	Patient Days	817,528	19	98,474	98,474	64,677	7,791	16
17	15	Emp. Ben. - Healthcare	Patient Days	817,528	19	128,421		64,677	10,160	17
18	17	Administration Salary	Patient Days	817,528	19	578,938	578,938	64,677	45,801	18
19	21	Office Salary	Patient Days	817,528	19	75,625	75,625	64,677	5,983	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	817,528	19	110,184		64,677	8,717	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,211,073	$ 1,536,540		$ 174,925	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			$	$		$	1
2	07	Emp. Ben. - General	Direct Allocation							2
3	10	Nursing / Medical Record Salary	Direct Allocation			344,209	344,209		12,783	3
4	12	Social Service / Admission Salary	Direct Allocation			174,668	174,668		734	4
5	15	Emp. Ben. - Healthcare	Direct Allocation			61,656			1,702	5
6	17	Administration Salary	Direct Allocation							6
7	27	Emp. Ben. - Gen. Admin.	Direct Allocation							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					$ 580,533	$ 518,877		$ 15,219	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			$	$		$ 2,389	1
2	2	Food	Direct Allocation							2
3	10	Nursing Supplies	Direct Allocation							3
4	39	Ancillary Expense	Direct Allocation						1,759	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					$	$		$ 4,147	25

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

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						44,585	2
3	4	Laundry	Direct Allocation						9,636	3
4	6	Repairs & Maintenance	Direct Allocation						6,591	4
5	10	Nursing	Direct Allocation						47,145	5
6	11	Activities	Direct Allocation							6
7	21	Office And Clerical	Direct Allocation							7
8	22	Employee Benefits	Direct Allocation						2,520	8
9	30	Fixed Assets-Depreciation	Direct Allocation							9
10	39	Ancillary	Direct Allocation						27,562	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					$	$		$ 138,038	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	39	Ventilator Equipment	Direct Allocation						286	1
2	39	Other Ancillary	Direct Allocation							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					$	$		$ 286	25

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			$	$		$ 94,437	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					$	$		$ 94,437	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			$	$		$	1
2	10	Nursing Supplies	Direct Allocation							2
3	39	Ancillary Expense	Direct Allocation						2,370	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					$	$		$ 2,370	25

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Partrners LLC		X	Mortgage			$	$ 9,370,493			$ 531,877	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	DAIWA		X	Line of Credit				987,568			15,527	6
7	Shareholder Loan	X		Line of Credit				300,000			2,250	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 10,658,061			$ 549,654	9
	B. Non-Facility Related*											
10	Interest Income (Facility)		X								(7,254)	10
11	Non-Allowable Interest										(2,250)	11
12	Allocated from EC Consulting		X								9,834	12
13	See Supplemental Schedule										562	13
14	TOTAL Non-Facility Related						$	$			$ 892	14
15	TOTALS (line 9+line14)						$	$ 10,658,061			$ 550,545	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 # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

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** 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							$	$			$	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 Clinical		X				$	$			$ 562	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related										562	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 # 0040444 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 173,558	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.)		$ 174,580	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,022	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 181,114	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.**		$	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.		$ 182,136	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	196,673	8
	2007	194,573	9
	2008	196,526	10
	2009	165,293	11
	2010	172,489	12

2011 Accrual =$172,489 x 1.05 = $181,114
Allocated from EC Consulting = $1,773
Allocated from EC Clinical = $318

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sheridan Shores Care 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 2010 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 2010.

	(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	$ 86,244.67	$ 86,244.67
2.	14-05-402-028-0000	Long Term Care Property	$ 86,244.67	$ 86,244.67
3.	See Attached	Allocation From 2201 Main	$ 126,481.18	$ 2,919.42
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 298,970.52	$ 175,408.76

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 and 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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sheridan Shores Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040444

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

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

	(A) 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			18,927	2
3	TOTALS			$ 709,850	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	191			1977	$ 4,446,256	$ 116,132	39	$ 114,007	$ (2,125)	$ 803,097	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	42,874		20	2,144	2,144	39,315	9
10	Various			1994	57,552		20	2,878	2,878	50,587	10
11	Various			1995	146,433		20	7,322	7,322	121,939	11
12	Various			1996	67,704		20	3,385	3,385	52,790	12
13	Various			1997	53,902		20	2,695	2,695	39,212	13
14	Various			1998	172,679		20	8,634	8,634	117,396	14
15	Various			1999	62,682		20	3,134	3,134	39,367	15
16	Various			2000	149,525		20	7,450	7,450	86,350	16
17	Various			2001	56,462		20	2,823	2,823	30,429	17
18	Various			2002	66,781		20	5,582	5,582	60,683	18
19	Various			2003	90,560		20	5,028	5,028	83,919	19
20	Various			2004	93,862		20	7,732	7,732	70,016	20
21	Various			2005	446,038		20	23,842	23,842	157,710	21
22	Various			2006	105,189		20	10,089	10,089	58,821	22
23	Various			2007	43,478		20	4,724	4,724	21,308	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 # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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
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59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		76,646	5,211		5,304	93	41,560	68
69	Financial Statement Depreciation			149,434			(149,434)		69
70	TOTAL (lines 4 thru 69)		$ 6,178,624	$ 270,777		$ 216,771	$ (54,006)	$ 1,874,498	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 # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 6,178,624	$ 270,777		$ 216,771	$ (54,006)	$ 1,874,498	1
2	Modernize Elevators	2008			20				2
3	Replace Air Filter;Radiator;Coolant & Coolant Disposal	2008	3,203		20	320	320	1,228	3
4	Replace Boiler And Hot Water Leaking Pipes	2008	2,835		20	236	236	906	4
5	3 Deluxe Pressure Guards	2008	3,719		20	372	372	1,426	5
6	New Power Lines For Washer & Dryer	2008	6,100		20	610	610	2,186	6
7	Repairs To Walk In Freezer	2008	3,108		20	311	311	1,088	7
8	Fire Safety Equipment	2008	3,306		20	331	331	1,074	8
9	Wiring For Wireless Matix Access	2008	8,162		20	816	816	2,721	9
10	Electrical Installation For Elevator Upgrade	2008	23,950		20	2,395	2,395	7,385	10
11	Repairs To Garage Door	2008	3,089		20	309	309	952	11
12	Elevator Feeder Upgrade	2008	5,600		20	280	280	863	12
13	Freezer	2009	3,271		20	654	654	1,908	13
14	Elevator Repairs	2009	16,376		20	1,638	1,638	4,776	14
15	Water Storage Tank	2009	6,355		20	1,271	1,271	3,389	15
16	Refrigeration Repairs	2009	4,673		20	935	935	2,414	16
17	Elevator Repairs	2009	2,833		20	283	283	708	17
18	A/C Wall Unit	2009	3,088		20	618	618	1,544	18
19	Ejector Pump Repair	2009	5,203		20	520	520	1,257	19
20	Refrigeration Repairs	2009	2,566		20	513	513	1,197	20
21	Masonary Inspection	2009	3,810		20	381	381	857	21
22	Roof Repair	2009	7,480		20	748	748	1,621	22
23	Modernize Elevators	2009	249,785		20	12,489	12,489	26,019	23
24	Replaced Burners In Heating Boiler	2010	2,500		20	250	250	500	24
25	Rebuild Brick Wall, Brick, Tuckpointing, Concrete, Lighting	2010	9,520		20	1,692	1,692	3,383	25
26	Reaplce Boiler Room Storge Tanks	2010	7,485		20	749	749	1,435	26
27	Install Doors In Masonry Walls, Replace Damaged Blocks	2010	4,031		20	403	403	672	27
28	Wall A/C Unit	2010	4,310		20	862	862	1,221	28
29	Fire Alarm System Devices	2010	4,481		20	448	448	635	29
30	Wiring For Generator	2010	6,307		20	631	631	841	30
31	Fire Suppression System	2010	3,006		20	301	301	326	31
32	Used Generator	2010	43,500		20	8,700	8,700	10,150	32
33	Repair Water Leak	2010	4,862		20	486	486	770	33
34	TOTAL (lines 1 thru 33)		$ 6,637,139	$ 270,777		$ 257,322	$ (13,455)	$ 1,959,951	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 # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 6,637,139	$ 270,777		$ 257,322	$ (13,455)	$ 1,959,951	1
2	Repalce Countertop Laminate On 5Th, 6Th And 7Th Floor	2010	4,763		20	476	476	754	2
3	Masonry Repair	2010	14,280		20	1,428	1,428	2,261	3
4	Leak Repair In Kitchen Storage Room	2010	6,533		20	653	653	1,034	4
5	Installation Of New Rental Unit	2011	3,681		20	368	368	368	5
6	Sprinkler System Repair	2011	2,854		20	238	238	238	6
7	Supply & Install Automatic Transfer Switches	2011	5,156		20	773	773	773	7
8	Rear Parking Lot Beans & Slab	2011	18,900		20	630	630	630	8
9	Remove Doors & Frames And Replace With New Fire-Rated Door	2011	5,014		20	334	334	334	9
10	Fire Damper Service	2011	5,634		20	329	329	329	10
11	Drywall	2011	3,500		20	204	204	204	11
12	Install Fire Dampers	2011	16,350		20	545	545	545	12
13	Satellite Cable Installation	2011	3,099		20	77	77	77	13
14	Garage Structure Repair	2011	32,500		20	542	542	542	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,759,402	$ 270,777		$ 263,920	$ (6,857)	$ 1,968,041	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 # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 6,759,402	$ 270,777		$ 263,920	$ (6,857)	$ 1,968,041	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,759,402	$ 270,777		$ 263,920	$ (6,857)	$ 1,968,041	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 # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 6,759,402	$ 270,777		$ 263,920	$ (6,857)	$ 1,968,041	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,759,402	$ 270,777		$ 263,920	$ (6,857)	$ 1,968,041	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 # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
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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 # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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
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28									28
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30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$	$		$	$	$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	22,112	567	39	567		5,268	3
4	Allocated From Extended Care Clinical 2201 Main LLC	2002	3,970	102	39	102		946	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From Extended Care Consulting	2007	223	11	20	11		56	9
10	Allocated From Extended Care Consulting	2009	133	7	20	7		20	10
11	Allocated From Extended Care Consulting	2010	1,310	65	20	65		131	11
12	Allocated From Extended Care Consulting	2011	471	24	20	24		24	12
13									13
14	Allocated From Extended Care Consulting 2201 Main LLC	2002	18,266	1,669	20	1,669		13,371	14
15	Allocated From Extended Care Consulting 2201 Main LLC	2003	21,526	1,967	20	1,967		15,757	15
16	Allocated From Extended Care Consulting 2201 Main LLC	2005	1,070	114	20	114		613	16
17	Allocated From Extended Care Consulting 2201 Main LLC	2009	193	10	20	10		29	17
18									18
19	Allocated From Extended Care Clinical 2201 Main LLC	2002	3,280	300	20	300		2,401	19
20	Allocated From Extended Care Clinical 2201 Main LLC	2003	3,865	353	20	353		2,829	20
21	Allocated From Extended Care Clinical 2201 Main LLC	2005	192	20	20	110	90	110	21
22	Allocated From Extended Care Clinical 2201 Main LLC	2009	35	2	20	5	3	5	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 # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 76,646	$ 5,211		$ 5,304	$ 93	$ 41,560	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 # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 950,639	$ 6,978	$ 13,511	$ 6,533	10	$ 920,208	71
72	Current Year Purchases	159	16	16		10	16	72
73	Fully Depreciated Assets	498,349				10	498,349	73
74								74
75	TOTALS	$ 1,449,147	$ 6,994	$ 13,527	$ 6,533		$ 1,418,573	75

D. Vehicle Costs. (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	2011	$ 1,219	$ 244	$ 244	$	5	$ 975	76
77		Allocated From EC Consulting	2011	14,389				5	14,389	77
78		Allocated From EC Clinical	2011	4,422	884	884		5	2,948	78
79										79
80	TOTALS			$ 20,030	$ 1,128	$ 1,128	$		$ 18,312	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)	$ 8,938,429	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 278,899	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 278,575	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (324)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,404,926	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 # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 14,354 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	$ 7,898	17
18					18
19					19
20					20
21	TOTAL		$ 544.00	$ 7,898	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 # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

STATE OF ILLINOIS
0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$		$ 53,040	$		$ 53,040	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			70,106			70,106	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			86,529			86,529	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				130,653		130,653	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					1,797	58,062		59,859	13
14	TOTAL			$		$ 211,472	$ 188,715		$ 400,187	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 **#** 0040444 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/11 **(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	$ 1,707	$ 64,351	1
2	Cash-Patient Deposits	38,719	38,719	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,031,149	2,031,149	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	268,662	268,662	6
7	Other Prepaid Expenses	21,692	21,692	7
8	Accounts Receivable (owners or related parties)	77,574	5,438,387	8
9	Other(specify): See Attached Schedule		50,921	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,439,503	$ 7,913,881	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	2,058,225	2,110,044	15
16	Equipment, at Historical Cost	897,121	1,484,405	16
17	Accumulated Depreciation (book methods)	(2,158,403)	(3,466,822)	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	4,518,833	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,942,480	$ 9,731,820	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,381,983	$ 17,645,701	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,991,300	$ 1,991,298	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,140	26,140	28
29	Short-Term Notes Payable	987,568	987,568	29
30	Accrued Salaries Payable	330,991	330,991	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,711	16,711	31
32	Accrued Real Estate Taxes(Sch.IX-B)	181,114	181,114	32
33	Accrued Interest Payable	123,254	168,154	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	4,794,495	4,261,540	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 8,451,573	$ 7,963,516	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	300,000	300,000	39
40	Mortgage Payable		9,370,493	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	$ 9,670,493	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,751,573	$ 17,634,009	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,369,590)	$ 11,692	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,381,983	$ 17,645,701	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Sheridan Shores Care # 0040444 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,688,602)	1
2	Restatements (describe):		2
3	Rounding	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,688,600)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	319,010	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)**	$ 319,010	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)**	$ (1,369,590)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 9,250,827	1
2	Discounts and Allowances for all Levels	(833,527)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,417,300	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	788,025	6
7	Oxygen	8,510	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 796,535	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	128,084	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,125	19
20	Radiology and X-Ray	2,010	20
21	Other Medical Services	17,956	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 158,175	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,254	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,254	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,912	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,912	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,381,176	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,568,477	31
32	Health Care	3,091,490	32
33	General Administration	2,113,074	33
	B. Capital Expense		
34	Ownership	1,476,029	34
	C. Ancillary Expense		
35	Special Cost Centers	425,376	35
36	Provider Participation Fee	387,720	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,062,166	40
41	**Income before Income Taxes (line 30 minus line 40)****	319,010	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 319,010	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 # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	2,021	2,146	$ 85,460	$ 39.82	1
2	Assistant Director of Nursing	2,106	2,193	77,242	35.22	2
3	Registered Nurses	10,928	13,344	357,501	26.79	3
4	Licensed Practical Nurses	35,553	38,939	926,024	23.78	4
5	CNAs & Orderlies	77,000	86,563	888,667	10.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,021	8,722	117,079	13.42	8
9	Activity Director	1,891	2,219	43,573	19.64	9
10	Activity Assistants	8,971	9,774	105,565	10.80	10
11	Social Service Workers	17,545	18,646	308,365	16.54	11
12	Dietician					12
13	Food Service Supervisor	1,954	2,101	39,722	18.91	13
14	Head Cook					14
15	Cook Helpers/Assistants	3,921	4,417	51,798	11.73	15
16	Dishwashers	14,783	16,711	163,636	9.79	16
17	Maintenance Workers	14,448	16,379	234,031	14.29	17
18	Housekeepers	20,936	23,339	224,688	9.63	18
19	Laundry	7,693	8,540	88,256	10.33	19
20	Administrator	4,116	4,550	210,016	46.16	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,054	6,929	95,059	13.72	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	1,709	1,989	26,889	13.52	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	322	411	5,405	13.17	33
34	TOTAL (lines 1 - 33)	239,972	267,912	$ 4,048,976 *	$ 15.11	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	204	$ 9,115	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	11,528	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	17,100	12-03	45
46	Other(specify)				46
47	Psychiatrist	Monthly	7,300	10-03	47
48	See Attached		13,517		48
49	TOTAL (lines 35 - 48)	204	$ 62,160		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 # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nathan Langsner	Administrator	0.00%	$ 136,189
Kayla Moore	Administrator	0.00%	73,827
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 210,016

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 6,941
Frost, Ruttenberg & Rothblatt	Accounting	25,100
Extended Care Consulting	Home Office Expense	296,028
Extended Care Clinical	Home Office Expense	98,676
Personnel Planners, Inc	Unemployment Consulting	2,954
Pinnacle Consulting	Customer Satisfaction	1,138
Daiwa	Line of Credit Audit	19,864
Extended Care Consulting	Other Professional Services	2,910
Extended Care Clinical	Other Professional Services	179
Prospect Resources	Natural Gas Procurement	1,192
Moshe Calamaro & Associates	Structural Engineering	640
See Supplemetal Schedule		35,918
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 491,539

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 110,136
Unemployment Compensation Insurance	44,790
FICA Taxes	299,830
Employee Health Insurance	165,541
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Holiday Expense	3,400
Other Employee Welfare	3,344
Pension Expense	31,512
Employee Physicals	2,997
Chicago Head Tax	2,322
TOTAL (agree to Schedule V, line 22, col.8)	$ 663,872

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	$
Advertising: Employee Recruitment	321
Health Care Worker Background Check	1,500
(Indicate # of checks performed 150)	
Patient Background Checks 258	7,397
Dues & Subscriptions	19,080
Licenses & Fees	2,177
Advertising & Promotions	6,519
Allocated from EC Consulting	4,021
See Supplemental Schedule	192
Less: Public Relations Expense	( )
Non-allowable advertising	(6,519)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 34,687

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,174
Allocated from EC Consulting	222
Allocated from EC Clinical	2,368
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,764

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 # 0040444 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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 = $17,572**

(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. $ **4,461** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **387,720**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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? **N/A** 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? **No**
Attach invoices and a summary of services for all architect and appraisal fees.