		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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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 01/01/12 to 12/31/12 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: 01/01/12 Ending: 12/31/12

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	23,058	1
2		Skilled Pediatric (SNF/PED)			2
3	128	Intermediate (ICF)	128	46,848	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	191	TOTALS	191	69,906	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	61,780	328	3,628	65,736	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	61,780	328	3,628	65,736	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.03%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
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 3,628

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: 12/31/2012 Fiscal Year: 12/31/2012

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

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	244,981	45,038	8,394	298,413		298,413	(1,886)	296,527			1
2	Food Purchase		326,025		326,025		326,025	639	326,664			2
3	Housekeeping	234,165	54,141		288,306		288,306	654	288,960			3
4	Laundry	91,725	18,035		109,760		109,760		109,760			4
5	Heat and Other Utilities			182,546	182,546		182,546	946	183,492			5
6	Maintenance	215,279	48	180,622	395,949		395,949	(11,521)	384,428			6
7	Other (specify):*							1,609	1,609			7
8	**TOTAL General Services**	786,150	443,287	371,562	1,600,999		1,600,999	(9,559)	1,591,440			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	2,445,071	69,696	32,862	2,547,629		2,547,629	(2,542)	2,545,087			10
10a	Therapy	118,324			118,324		118,324		118,324			10a
11	Activities	137,394	23,197		160,591		160,591		160,591			11
12	Social Services	341,247	8,613	16,300	366,160		366,160		366,160			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							47	47			15
16	**TOTAL Health Care and Programs**	3,042,036	101,506	52,762	3,196,304		3,196,304	(2,495)	3,193,809			16
	C. General Administration											
17	Administrative	236,043		60,000	296,043		296,043	23,003	319,046			17
18	Directors Fees											18
19	Professional Services			240,048	240,048		240,048	(141,676)	98,372			19
20	Dues, Fees, Subscriptions & Promotions			34,790	34,790		34,790	(8,267)	26,523			20
21	Clerical & General Office Expenses	88,603	40,822	184,594	314,019		314,019	62,549	376,568			21
22	Employee Benefits & Payroll Taxes			730,663	730,663		730,663	(6,326)	724,337			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,239	8,239		8,239	304	8,543			24
25	Other Admin. Staff Transportation			11,115	11,115		11,115	1,133	12,248			25
26	Insurance-Prop.Liab.Malpractice			218,088	218,088		218,088	1,337	219,425			26
27	Other (specify):*							32,831	32,831			27
28	**TOTAL General Administration**	324,646	40,822	1,487,537	1,853,005		1,853,005	(35,112)	1,817,893			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,152,832	585,615	1,911,861	6,650,308		6,650,308	(47,166)	6,603,142			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: 01/01/12 Ending: 12/31/12

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			153,545	153,545		153,545	126,533	280,078			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,165	11,165		11,165	531,607	542,772			32
33	Real Estate Taxes			171,019	171,019		171,019	3,001	174,020			33
34	Rent-Facility & Grounds			491,739	491,739		491,739	(491,739)				34
35	Rent-Equipment & Vehicles			14,872	14,872		14,872	1,082	15,954			35
36	Other (specify):*											36
37	TOTAL Ownership			842,340	842,340		842,340	170,484	1,012,824			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		252,681	414,163	666,844		666,844	(215)	666,629			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			481,487	481,487		481,487		481,487			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		252,681	895,650	1,148,331		1,148,331	(215)	1,148,116			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,152,832	838,296	3,649,851	8,640,979		8,640,979	123,103	8,764,082			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: 01/01/12 Ending: 12/31/12

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	888	30		9
10	Interest and Other Investment Income	(4,621)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(16)	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	(515)	21		18
19	Entertainment				19
20	Contributions	(5,000)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(84,000)	21		24
25	Fund Raising, Advertising and Promotional	(2,059)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(25)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(120,914)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (216,262)		$	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)	339,365		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 339,365		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 123,103		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: 01/01/12

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Capitalized R&M	$ (26,313)	06	1
2	Collection Expense	(2,713)	21	2
3	Jury Duty Income	(86)	10	3
4	Medical Records Income	(82)	10	4
5	Patient Clothing	(2,374)	10	5
6	Additional R&M	2,289	06	6
7	Bldg Co. - Professional Fees	(17,500)	19	7
8	Bldg Co. - Bank Service Charges	(67)	21	8
9	Bldg Co. - Filing Fees	(250)	21	9
10	Bldg Co. - Amortization	(64,013)	31	10
11	Non Allowable Legal	(3,398)	19	11
12	Non Allowable Interest	(25)	32	12
13	Annual Report	(250)	20	13
14	Other Income	(211)	21	14
15	COPE Dues	(5,921)	20	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(120,914)		49

Sheridan Shores Care

ID# 0040444

Report Period Beginning: 01/01/12

Ending: 12/31/12

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

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			342			(2,228)						(1,886)	1
2	Food Purchase	(16)		655									639	2
3	Housekeeping			654									654	3
4	Laundry													4
5	Heat and Other Utilities			946									946	5
6	Maintenance	(24,024)		3,747	8,756								(11,521)	6
7	Other (specify):*				1,609								1,609	7
8	**TOTAL General Services**	(24,040)		6,344	10,365		(2,228)						(9,559)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(2,542)											(2,542)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					47							47	15
16	**TOTAL Health Care and Programs**	(2,542)				47							(2,495)	16
	C. General Administration													
17	Administrative			4,048	18,955								23,003	17
18	Directors Fees													18
19	Professional Services	(20,898)	17,500	(138,278)									(141,676)	19
20	Fees, Subscriptions & Promotions	(13,230)		4,963									(8,267)	20
21	Clerical & General Office Expenses	(87,781)	342	16,939	133,049								62,549	21
22	Employee Benefits & Payroll Taxes				(6,279)	(47)							(6,326)	22
23	Inservice Training & Education													23
24	Travel and Seminar			304									304	24
25	Other Admin. Staff Transportation			1,133									1,133	25
26	Insurance-Prop.Liab.Malpractice			1,337									1,337	26
27	Other (specify):*				32,831								32,831	27
28	**TOTAL General Administration**	(121,909)	17,842	(109,554)	178,556	(47)							(35,112)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(148,491)	17,842	(103,210)	188,921		(2,228)						(47,166)	29

STATE OF ILLINOIS

Summary B

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

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	888	116,132	9,513									126,533	30
31	Amortization of Pre-Op. & Org.	(64,013)	64,013											31
32	Interest	(4,646)	530,337	5,916									531,607	32
33	Real Estate Taxes			3,001									3,001	33
34	Rent-Facility & Grounds		(491,739)										(491,739)	34
35	Rent-Equipment & Vehicles			1,463				(381)					1,082	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(67,771)	218,743	19,893				(381)					170,484	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(199)		(16)			(215)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**							(199)		(16)			(215)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(216,262)	236,585	(83,317)	188,921		(2,228)	(580)		(16)			123,103	45

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

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	Rent	$ 491,739	Sheridan Shores Property LLC	100.00%	$	$ (491,739)	1
2	V	19	Professional Fees		Sheridan Shores Property LLC	100.00%	17,500	17,500	2
3	V	21	Bank Service Charges		Sheridan Shores Property LLC	100.00%	67	67	3
4	V	21	Filing Fees		Sheridan Shores Property LLC	100.00%	250	250	4
5	V	21	State Replacement Tax		Sheridan Shores Property LLC	100.00%	25	25	5
6	V	30	Depreciation		Sheridan Shores Property LLC	100.00%	116,132	116,132	6
7	V	31	Amortization		Sheridan Shores Property LLC	100.00%	64,013	64,013	7
8	V	32	Interest Expense		Sheridan Shores Property LLC	100.00%	530,337	530,337	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 491,739			$ 728,324	$ * 236,585	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: 01/01/12 Ending: 12/31/12

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%	$ 342	$ 342	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	655	655	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	654	654	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	946	946	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	3,747	3,747	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	4,048	4,048	20
21	V	19	Professional Fees	144,000	Extended Care Consulting, LLC	100.00%	5,722	(138,278)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	4,963	4,963	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	16,939	16,939	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	304	304	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,133	1,133	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,337	1,337	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	9,513	9,513	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	5,916	5,916	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	3,001	3,001	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%	1,463	1,463	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 144,000			$ 60,683	$ * (83,317)	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: 01/01/12 Ending: 12/31/12

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	8,756	$ 8,756	15
16	V	06	Maintenance (Direct)		Extended Care Consulting, LLC	100.00%			16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,609	1,609	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%			18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	18,955	18,955	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	133,049	133,049	22
23	V	21	Office and Clerical (Direct)	20,790	Extended Care Consulting, LLC	100.00%	20,790		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	27,928	27,928	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	4,903	4,903	25
26	V	22	Employee Benefits	6,279	Extended Care Consulting, LLC	100.00%		(6,279)	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			$ 27,069			$ 215,990	$ * 188,921	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: 01/01/12 Ending: 12/31/12

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	10	Nursing / Medical Record Salary	297	Extended Care Clinical, LLC	100.00%	297	$	15
16	V	12	Social Service / Admission Salary		Extended Care Clinical, LLC	100.00%			16
17	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	47	47	17
18	V	22	Employee Benefits	47	Extended Care Clinical, LLC	100.00%		(47)	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			$ 344			$ 344	$ *	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: 01/01/12 Ending: 12/31/12

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	$ 7,958	Care Centers Health Systems, Inc.	100.00%	$ 5,730	$ (2,228)	15
16	V	10	Nursing Supplies		Care Centers Health Systems, Inc.	100.00%			16
17	V	39	Ancillary Expense		Care Centers Health Systems, Inc.	100.00%			17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 7,958			$ 5,730	$ * (2,228)	39

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

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

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	350	Vent Lease LLC	100.00%	151	$ (199)	15
16	V	39	Other Ancillary		Vent Lease LLC	100.00%			16
17	V	35	Matrix Leasing	381	Vent Lease LLC	100.00%		(381)	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			$ 731			$ 151	$ * (580)	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: 01/01/12 Ending: 12/31/12

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 91,275	$ 91,275	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	91,275	CCS Employee Benefits Group	100.00%		(91,275)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 91,275			$ 91,275	$ *	39

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

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

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	Ancillary Expense	1,768	Reliable Medical of the Midwest, LLC	100.00%	1,752	$ (16)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,768			$ 1,752	$ * (16)	39

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

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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%	AVENUE CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	SHERIDAN SHORES PROPERTY	EVANSTON	BUILDING CO.	1
2	ERIC ROTHNER GRANTOR TRUST	29.787%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	EXTENDED CARE CONSULTING	EVANSTON	MANAGEMENT/BOOKKI	2
3	NATHAN & SHIRLEY ROTHNER FAMILY TR	54.255%	BOULEVARD CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	EXTENDED CARE CLINICAL	EVANSTON	ADMINISTRATIVE	3
4			BRIAR PLACE LTD	INDIAN HEAD PARK	CARE CENTER HEALTH SYSTE	DES PLAINES	DIETARY & FOOD SUPPI	4
5			CHATEAU NURSING AND REHABILITATION CENTER, LLC	WILLOWBROOK	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	5
6			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	ROTHNER VENTS LLC	EVANSTON	VENTALATOR RENTAL	6
7			DEVON GABLES REHABILITATION CENTER	ARIZONA	2201 MAIN, LLC	EVANSTON	BLDG COMPANY	7
8			DYER NURSING & REHAB	DYER, IN	RELIABLE MEDICAL OF THE M	DES PLAINES	MEDICAL SUPPLIES	8
9			FOOTHILLS REHABILITATION CENTER LLC	ARIZONA				9
10			GOLDEN PLAINES REHABILITATION CENTER	KANSAS				10
11			GRASMERE PLACE, LLC	CHICAGO				11
12			HILLCREST NURSING AND REHABILITATION CENTER,LLC	JOLIET				12
13			HOMESTEAD NURSING & REAHB	LINCOLN, NE				13
14			LAKE COUNTY NURSING & REHAB	EAST CHICAGO, IN				14
15			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD				15
16			LANCASTER MANOR	LINCOLN, NE				16
17			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT				17
18			MCKINLEY HEALTH CARE CENTER	CANTON, OH				18
19			OAK PARK HEALTHCARE CENTER, L.L.C.	OAK PARK				19
20			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				20
21			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				21
22			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				22
23			RAINBOW BEACH QOC, L.L.C.	CHICAGO				23
24			SEBOS NURSING & REHAB	HOLBART, IN				24
25			SHEFFIELD MANOR	DYER, IN				25
26			SNOW VALLEY NURSING AND REHABILITATION CENTER, L.L.C.	LISLE				26
27			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				27
28			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				28
29			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				29
30			WHEATON CARE CENTER	WHEATON				30

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

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

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	Mark Steinberg	Relative	Administrative	0.00%	See Attached	4.34	7.89%	Al Sal/Al Fee	$ 15,092	17-7	1
2	Adam Vales	Relative	Clerical	0.00%	See Attached	0.78	1.95%	Alloc Salary	1,432	22-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 16,524		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: 01/01/12 Ending: 12/31/12

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

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	1,364,178	31	$ 7,101	$	65,736	$ 342	1
2	02	Food	Patient Days	1,364,178	31	13,586		65,736	655	2
3	03	Housekeeping	Patient Days	1,364,178	31	13,573		65,736	654	3
4	05	Utilities	Patient Days	1,364,178	31	19,636		65,736	946	4
5	06	Maintenance	Patient Days	1,364,178	31	77,756		65,736	3,747	5
6	17	Administrative	Patient Days	1,364,178	31	84,000		65,736	4,048	6
7	19	Professional Fees	Patient Days	1,364,178	31	118,750		65,736	5,722	7
8	20	Dues and Subscriptions	Patient Days	1,364,178	31	102,984		65,736	4,963	8
9	21	Office and Clerical	Patient Days	1,364,178	31	351,528		65,736	16,939	9
10	24	Seminar and Travel	Patient Days	1,364,178	31	6,315		65,736	304	10
11	25	Other Staff Admin. Trans.	Patient Days	1,364,178	31	23,506		65,736	1,133	11
12	26	Insurance	Patient Days	1,364,178	31	27,741		65,736	1,337	12
13	30	Depreciation	Patient Days	1,364,178	31	197,424		65,736	9,513	13
14	32	Interest	Patient Days	1,364,178	31	122,765		65,736	5,916	14
15	33	Real Estate Taxes	Patient Days	1,364,178	31	62,275		65,736	3,001	15
16	34	Rent - Building	Patient Days	1,364,178	31			65,736		16
17	35	Rent - Equipment & Auto	Patient Days	1,364,178	31	30,363		65,736	1,463	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,259,303	$		$ 60,683	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	1,364,178	31	181,713	181,713	65,736	8,756	1
2	06	Maintenance (Direct)	Direct		31	256,754	256,754			2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,364,178	31	33,386		65,736	1,609	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	40,137				4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,364,178	31	393,362	393,362	65,736	18,955	7
8	21	Office and Clerical (Pooled)	Patient Days	1,364,178	31	2,761,089	2,761,089	65,736	133,049	8
9	21	Office and Clerical (Direct)	Direct		31	368,461	368,461		20,790	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,364,178	31	579,570		65,736	27,928	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	65,039			4,903	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					$ 4,679,511	$ 3,961,379		$ 215,990	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	10	Nursing / Medical Record Salary	Direct Allocation			10,300	10,300		297	1
2	12	Social Service / Admission Salary	Direct Allocation			6,057	6,057			2
3	15	Emp. Ben. - Healthcare	Direct Allocation			2,077			47	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					$ 18,434	$ 16,357		$ 344	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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			$	$		$ 5,730	1
2	10	Nursing Supplies	Direct Allocation							2
3	39	Ancillary Expense	Direct Allocation							3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 5,730	25

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

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						151	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					$	$		$ 151	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation			$	$		$ 91,275	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 91,275	25

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

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	39	Ancillary Expense	Direct Allocation						1,752	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					$	$		$ 1,752	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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: 01/01/12 Ending: 12/31/12

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Business Partners, LLC		X	Mortgage			$	$ 9,096,197			$ 530,337	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Shareholder Loan	X		Line of Credit				222,574				6
7	DAIWA		X	Line of Credit							11,140	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 9,318,771			$ 541,477	9
	B. Non-Facility Related*											
10	Interest Income		X								(4,621)	10
11	Allocated from EC Consulting		X								5,916	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ 1,295	14
15	TOTALS (line 9+line14)						$	$ 9,318,771			$ 542,772	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: 01/01/12 Ending: 12/31/12

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							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 181,114	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.)		$ 174,773	2
3. Under or (over) accrual (line 2 minus line 1).		$ (6,341)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 180,361	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.		$ 174,020	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	194,573	8
	2008	196,526	9
	2009	165,293	10
	2010	172,489	11
	2011	171,772	12

2012 Accrual = $171,772 x 1.05
Allocated from EC Consulting = $3,001

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 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 2011 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 2011.

	(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	$ 85,885.97	$ 85,885.97
2.	14-05-402-028-0000	Long Term Care Property	$ 85,885.97	$ 85,885.97
3.	See Attached	Allocation From 2201 Main	$ 127,119.67	$ 2,384.22
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 298,891.61	$ 174,156.16

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

IMPORTANT NOTICE

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

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

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

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

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

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			15,379	2
3	TOTALS			$ 706,302	3

SEE ACCOUNTANTS' COMPILATION REPORT

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

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)	$ 917,104	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	42,874		20	2,144	2,144	41,459	9
10	Various			1994	57,552		20	2,878	2,878	53,465	10
11	Various			1995	146,433		20	7,322	7,322	129,260	11
12	Various			1996	67,704		20	3,385	3,385	56,175	12
13	Various			1997	53,902		20	2,695	2,695	41,907	13
14	Various			1998	172,679		20	8,634	8,634	126,029	14
15	Various			1999	62,682		20	3,134	3,134	42,501	15
16	Various			2000	149,525		20	7,450	7,450	93,800	16
17	Various			2001	56,462		20	2,823	2,823	33,252	17
18	Various			2002	66,781		20	2,146	2,146	62,829	18
19	Various			2003	90,560		20	5,028	5,028	88,947	19
20	Various			2004	93,862		20	7,453	7,453	77,470	20
21	Various			2005	446,038		20	23,842	23,842	181,552	21
22	Various			2006	105,189		20	9,873	9,873	68,695	22
23	Various			2007	43,478		20	4,675	4,675	25,983	23
24	Various			2008	63,072		20	5,980	5,980	25,808	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: 01/01/12 Ending: 12/31/12

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
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		62,821	4,261		4,261		38,072	68
69	Financial Statement Depreciation			153,545			(153,545)		69
70	TOTAL (lines 4 thru 69)		$ 6,227,871	$ 273,938		$ 217,730	$ (56,208)	$ 2,104,308	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: 01/01/12 Ending: 12/31/12

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		$ 6,227,871	$ 273,938		$ 217,730	$ (56,208)	$ 2,104,308	1
2	Freezer	2009	3,271		20	654	654	2,562	2
3	Elevator Repairs	2009	16,376		20	1,638	1,638	6,414	3
4	Water Storage Tank	2009	6,355		20	1,271	1,271	4,660	4
5	Refrigeration Repairs	2009	4,673		20	935	935	3,349	5
6	Elevator Repairs	2009	2,833		20	283	283	992	6
7	A/C Wall Unit	2009	3,088		20	618	618	2,162	7
8	Ejector Pump Repair	2009	5,203		20	520	520	1,778	8
9	Refrigeration Repairs	2009	2,566		20	513	513	1,711	9
10	Masonary Inspection	2009	3,810		20	381	381	1,238	10
11	Roof Repair	2009	7,480		20	748	748	2,369	11
12	Modernize Elevators	2009	249,785		20	12,489	12,489	38,509	12
13	Replaced Burners In Heating Boiler	2010	2,500		20	250	250	750	13
14	Rebuild Brick Wall, Brick, Tuckpointing, Concrete, Lighting	2010	9,520		20	952	952	2,856	14
15	Reaplce Boiler Room Storge Tanks	2010	7,485		20	749	749	2,183	15
16	Install Doors In Masonry Walls, Replace Damaged Blocks	2010	4,031		20	403	403	1,075	16
17	Wall A/C Unit	2010	4,310		20	862	862	2,083	17
18	Fire Alarm System Devices	2010	4,481		20	448	448	1,083	18
19	Wiring For Generator	2010	6,307		20	631	631	1,472	19
20	Fire Suppression System	2010	3,006		20	301	301	626	20
21	Used Generator	2010	43,500		20	8,700	8,700	18,850	21
22	Repair Water Leak	2010	4,862		20	486	486	1,256	22
23	Repalce Countertop Laminate On 5Th, 6Th And 7Th Floor	2010	4,763		20	476	476	1,230	23
24	Masonry Repair	2010	14,280		20	1,428	1,428	3,689	24
25	Leak Repair In Kitchen Storage Room	2010	6,533		20	653	653	1,688	25
26	Installation Of New Rental Unit	2011	3,681		20	368	368	736	26
27	Sprinkler System Repair	2011	2,854		20	285	285	523	27
28	2 Automatic Transfer Switches	2011	5,156		20	1,031	1,031	1,805	28
29	New Parking Lot Beans & Slab	2011	18,900		20	945	945	1,575	29
30	Replace Doors, Fix Drywall & Tile	2011	5,014		20	501	501	836	30
31	Fire Damper Service	2011	5,634		20	563	563	892	31
32	Drywall	2011	3,500		20	350	350	554	32
33	Install Fire Dampers	2011	16,350		20	1,635	1,635	2,180	33
34	TOTAL (lines 1 thru 33)		$ 6,709,978	$ 273,938		$ 259,798	$ (14,140)	$ 2,217,992	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: 01/01/12 Ending: 12/31/12

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		$ 6,709,978	$ 273,938		$ 259,798	$ (14,140)	$ 2,217,992	1
2	Satellite Cable Installation	2011	3,099		20	310	310	387	2
3	Garage Structure Repair	2011	32,500		20	3,250	3,250	3,792	3
4	Front Lobby - Doors & Walls Installation	2012	10,850		20	1,085	1,085	1,085	4
5	Lobby - Grids & Tiles Installation	2012	3,955		20	330	330	330	5
6	Supply & Exhaust-Ducting With Fire Dampers Installation	2012	4,850		20	404	404	404	6
7	Control Valve Replacement	2012	4,430		20	295	295	295	7
8	Flooring - 1St Fl Lobby, Entrance & Corridors	2012	12,400		20	620	620	620	8
9	Security Camera System	2012	3,895		20	390	390	390	9
10	3 New Volt Circuits & Outlets	2012	2,950		20	123	123	123	10
11	Storage Tank	2012	6,364		20	265	265	265	11
12	Fire Dampers & Exhaust Fan	2012	2,653		20	66	66	66	12
13	Basement Compressor & Electrical Work	2012	6,244		20	156	156	156	13
14	Replace Copper Piping Across Basement Ceiling	2012	9,300		20	39	39	39	14
15	Smoke Damper Repairs	2012	4,612		20	96	96	96	15
16	Wiring - Generator To Control	2012	7,000		20	350	350	350	16
17	Install Hot Water Pump	2012	2,706		20	135	135	135	17
18	Repair West Elevation Steel Door	2012	2,695		20	135	135	135	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,830,480	$ 273,938		$ 267,847	$ (6,091)	$ 2,226,660	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: 01/01/12 Ending: 12/31/12

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		$ 6,830,480	$ 273,938		$ 267,847	$ (6,091)	$ 2,226,660	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
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,830,480	$ 273,938		$ 267,847	$ (6,091)	$ 2,226,660	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: 01/01/12 Ending: 12/31/12

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		$ 6,830,480	$ 273,938		$ 267,847	$ (6,091)	$ 2,226,660	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,830,480	$ 273,938		$ 267,847	$ (6,091)	$ 2,226,660	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: 01/01/12 Ending: 12/31/12

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
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (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: 01/01/12 Ending: 12/31/12

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	21,194	543	39	543		5,593	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From Extended Care Consulting	2007	222	11	20	11		66	9
10	Allocated From Extended Care Consulting	2009	133	7	20	7		27	10
11	Allocated From Extended Care Consulting	2010	1,300	65	20	65		195	11
12	Allocated From Extended Care Consulting	2011	468	23	20	23		47	12
13	Allocated From Extended Care Consulting	2012	154	8	20	8		8	13
14									14
15	Allocated From Extended Care Consulting 2201 Main LLC	2002	17,508	1,600	20	1,600		14,415	15
16	Allocated From Extended Care Consulting 2201 Main LLC	2003	20,632	1,886	20	1,886		16,988	16
17	Allocated From Extended Care Consulting 2201 Main LLC	2005	1,025	109	20	109		696	17
18	Allocated From Extended Care Consulting 2201 Main LLC	2009	185	9	20	9		37	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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
12									12
13									13
14									14
15									15
16									16
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 62,821	$ 4,261		$ 4,261	$	$ 38,072	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: 01/01/12 Ending: 12/31/12

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	$ 881,475	$ 1,085	$ 5,813	$ 4,728	10	$ 862,120	71
72	Current Year Purchases	80,626	2,674	4,924	2,250	10	51,351	72
73	Fully Depreciated Assets	513,294				10	513,294	73
74								74
75	TOTALS	$ 1,475,395	$ 3,759	$ 10,738	$ 6,979		$ 1,426,765	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	2012	$ 7,468	$ 1,494	$ 1,494	$	5	$ 7,468	76
77										77
78										78
79										79
80	TOTALS			$ 7,468	$ 1,494	$ 1,494	$		$ 7,468	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)	$ 9,019,645	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 279,191	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 280,079	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 888	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,660,893	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: 01/01/12 Ending: 12/31/12

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.	/2013	$
13.	/2014	$
14.	/2015	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 6,570 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	$ 698.69	$ 9,385	17
18					18
19					19
20					20
21	TOTAL		$ 698.69	$ 9,385	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: 01/01/12 Ending: 12/31/12

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

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	$		$ 185,730	$		$ 185,730	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			31,868			31,868	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			198,069			198,069	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				178,164		178,164	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					(1,504)	74,517		73,013	13
14	TOTAL			$		$ 414,163	$ 252,681		$ 666,844	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: 01/01/12 Ending: 12/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12 (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	$ 5,626	$ 161,207	1
2	Cash-Patient Deposits	33,532	33,532	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	963,270	963,270	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	215,489	215,489	6
7	Other Prepaid Expenses	1,870	1,870	7
8	Accounts Receivable (owners or related parties)		5,285,813	8
9	Other(specify): See Attached Schedule	1,585,781	1,859,671	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,805,568	$ 8,520,852	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	2,112,920	2,164,739	15
16	Equipment, at Historical Cost	932,312	1,519,596	16
17	Accumulated Depreciation (book methods)	(2,311,948)	(3,736,499)	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	4,454,820	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,878,821	$ 9,488,016	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,684,389	$ 18,008,868	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 6,589,698	$ 6,589,698	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,624	28,624	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	219,060	219,060	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,220	7,220	31
32	Accrued Real Estate Taxes(Sch.IX-B)	180,361	180,361	32
33	Accrued Interest Payable	123,254	166,840	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	176,593	176,593	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,324,810	$ 7,368,396	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	222,574	222,574	39
40	Mortgage Payable		9,096,197	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)**	$ 222,574	$ 9,318,771	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,547,384	$ 16,687,167	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 137,005	$ 1,321,701	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,684,389	$ 18,008,868	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,369,590)	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,369,589)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,506,594	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)**	$ 1,506,594	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)**	$ 137,005	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,031,582	1
2	Discounts and Allowances for all Levels	(2,050,282)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,981,300	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,920,596	6
7	Oxygen	3,972	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,924,568	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	204,349	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,052	19
20	Radiology and X-Ray	2,570	20
21	Other Medical Services	17,734	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 236,705	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,621	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,621	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	379	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 379	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,147,573	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,600,999	31
32	Health Care	3,196,304	32
33	General Administration	1,853,005	33
	B. Capital Expense		
34	Ownership	842,340	34
	C. Ancillary Expense		
35	Special Cost Centers	666,844	35
36	Provider Participation Fee	481,487	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,640,979	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,506,594	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,506,594	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,042,672	44
45	Private Pay - Net Inpatient Revenue	49,974	45
46	Medicare - Net Inpatient Revenue	(183,655)	46
47	Other-(specify) Hospice	72,309	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,981,300	49

* **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.**

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	2,572	2,761	$ 127,974	$ 46.35	1
2	Assistant Director of Nursing	2,074	2,104	68,696	32.65	2
3	Registered Nurses	14,736	16,948	482,024	28.44	3
4	Licensed Practical Nurses	33,085	35,697	857,954	24.03	4
5	CNAs & Orderlies	74,863	82,497	886,355	10.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,118	8,860	118,324	13.35	8
9	Activity Director	1,763	1,826	36,082	19.76	9
10	Activity Assistants	8,982	9,891	101,312	10.24	10
11	Social Service Workers	18,070	18,904	341,247	18.05	11
12	Dietician					12
13	Food Service Supervisor	2,015	2,125	40,155	18.90	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,251	4,589	55,298	12.05	15
16	Dishwashers	13,907	15,556	149,528	9.61	16
17	Maintenance Workers	14,128	15,940	215,279	13.51	17
18	Housekeepers	21,493	24,069	234,165	9.73	18
19	Laundry	7,923	8,592	91,725	10.68	19
20	Administrator	4,149	4,534	236,043	52.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,392	7,220	88,603	12.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,674	1,837	22,068	12.01	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	240,195	263,950	$ 4,152,832 *	$ 15.73	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	181	$ 8,394	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	12,165	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	16,300	12-03	45
46	Other(specify)				46
47	Psychiatrist	Monthly	20,400	10-03	47
48	See Attached		297		48
49	TOTAL (lines 35 - 48)	181	$ 61,156		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: 01/01/12 Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kayla Moore	Administrator	0	$ 103,859
Nachum Langsner	Administrator	0	132,184
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 236,043

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
Frost, Ruttenberg & Rothblatt	Accounting	$ 25,450
See Attached	Legal	6,500
Personnel Planners, Inc.	Unemployment Consult	1,592
Extended Care Consulting	Home Office Expense	144,000
Bylmas	Tax Credit Services	3,936
Collaborative Healthcare	Emergency Services	175
National Datacare Corporation	Resident Fund Processing	2,431
Hamlin & Burton	Liability Insurance	29
Legat Architects	Miscellaneous Consltg	2,553
Pinnacle Quality Insight	Customer Satisfaction	1,138
Prospect Resources	Natural Gas Procurement	1,300
See Supplemetal Schedule		50,946
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 240,050

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 107,872
Unemployment Compensation Insurance	79,121
FICA Taxes	313,900
Employee Health Insurance	171,927
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	39,743
Employee Physicals	4,193
Other Employee Welfare	4,099
Holiday Expense	3,329
Chicago Head Tax	153
TOTAL (agree to Schedule V, line 22, col.8)	$ 724,337

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	1,510
Health Care Worker Background Check	
(Indicate # of checks performed 73)	3,259
Patient Background Checks	
Dues & Subscriptions	13,969
Licenses & Fees	2,822
Allocated from EC Consulting	4,963
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,523

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	8,239
Allocated from Extended Care Consulting	304
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,543

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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 = $18,336**

(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? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **7,725** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **481,487**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **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? **YES**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT