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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0040444

Facility Name: Sheridan Shores Cr & Reh Ctr

Address: 5838 N Sheridan Rd (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: 6/4/1993

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/14 to 12/31/14 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

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		204	4,415	4,619	8
9	SNF/PED					9
10	ICF	60,877			60,877	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	60,877	204	4,415	65,496	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.95%

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 4,267

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: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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	274,085	42,458	13,162	329,705		329,705	212	329,917			1
2	Food Purchase		357,427		357,427		357,427	939	358,366			2
3	Housekeeping	213,023	48,047		261,070		261,070	711	261,781			3
4	Laundry	105,610	20,682		126,292		126,292		126,292			4
5	Heat and Other Utilities			233,515	233,515		233,515	1,603	235,118			5
6	Maintenance	190,665	16	256,151	446,832		446,832	(28,855)	417,977			6
7	Other (specify):*							1,081	1,081			7
8	**TOTAL General Services**	783,383	468,630	502,828	1,754,841		1,754,841	(24,309)	1,730,532			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	2,757,618	108,913	36,653	2,903,184		2,903,184	(1,730)	2,901,454			10
10a	Therapy	140,070			140,070		140,070		140,070			10a
11	Activities	123,275	21,306		144,581		144,581		144,581			11
12	Social Services	374,862	8,871	23,000	406,733		406,733		406,733			12
13	CNA Training											13
14	Program Transportation			751	751		751		751			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,395,825	139,090	64,004	3,598,919		3,598,919	(1,730)	3,597,189			16
	C. General Administration											
17	Administrative	172,400			172,400		172,400	28,164	200,564			17
18	Directors Fees											18
19	Professional Services			295,303	295,303		295,303	(134,728)	160,575			19
20	Dues, Fees, Subscriptions & Promotions			51,544	51,544		51,544	(18,329)	33,215			20
21	Clerical & General Office Expenses	92,104	39,728	180,561	312,393		312,393	62,666	375,059			21
22	Employee Benefits & Payroll Taxes			834,690	834,690		834,690	(6,402)	828,288			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,463	8,463		8,463	(3,204)	5,259			24
25	Other Admin. Staff Transportation			18,223	18,223		18,223	1,795	20,018			25
26	Insurance-Prop.Liab.Malpractice			188,174	188,174		188,174	1,930	190,104			26
27	Other (specify):*							34,825	34,825			27
28	**TOTAL General Administration**	264,504	39,728	1,576,958	1,881,190		1,881,190	(33,283)	1,847,907			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,443,712	647,448	2,143,790	7,234,950		7,234,950	(59,323)	7,175,627			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
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 Cr & Reh Ctr #0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			166,914	166,914		166,914	146,255	313,169			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							519,233	519,233			32
33	Real Estate Taxes			229,929	229,929		229,929	3,466	233,395			33
34	Rent-Facility & Grounds			936,000	936,000		936,000	(936,000)				34
35	Rent-Equipment & Vehicles			21,168	21,168		21,168	1,055	22,223			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,354,011	1,354,011		1,354,011	(265,991)	1,088,020			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		295,602	669,188	964,790		964,790	(2,172)	962,618			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			475,913	475,913		475,913		475,913			42
43	Other (specify):*	351,440		60,000	411,440		411,440	(411,440)				43
44	**TOTAL Special Cost Centers**	351,440	295,602	1,205,101	1,852,143		1,852,143	(413,612)	1,438,531			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,795,152	943,050	4,702,902	10,441,104		10,441,104	(738,926)	9,702,178			45

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

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	9,773	30		9
10	Interest and Other Investment Income	(44,698)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(11)	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				18
19	Entertainment				19
20	Contributions	(7,074)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(87,046)	21		24
25	Fund Raising, Advertising and Promotional	(2,180)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(537,317)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (668,553)		$	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)	(70,373)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (70,373)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (738,926)		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

STATE OF ILLINOIS **Page 5A**

Sheridan Shores Cr & Reh Ctr

ID# **0040444**

Report Period Beginning: **01/01/14**

Ending: **12/31/14**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Jury Duty Income	$ (17)	10	1
2	Patient Clothing	(597)	10	2
3	Collection Expense	(2,937)	21	3
4	Capitalized R&M	(11,328)	06	4
5	PAC Dues	(11,410)	20	5
6	Non Allowable Seminar	(2,530)	24	6
7	2015 Seminar	(1,040)	24	7
8	Out of Period Fees	(2,803)	21	8
9	Non Allowable Legal Fees	(3,264)	19	9
10	Bldg Co. - Management Fees	(2,350)	17	10
11	Bldg Co. - Bank Charges	(55)	21	11
12	Bldg Co. - Filing Fees	(250)	20	12
13	Bldg Co. - Amortization	(51,755)	31	13
14	Additional Capitalized R&M	(35,540)	06	14
15	Non Allowable Compensation	(351,440)	43	15
16	Non Allowable Fees	(60,000)	43	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**	(537,317)		49

Sheridan Shores Cr & Reh Ctr

ID# 0040444

Report Period Beginning: 01/01/14

Ending: 12/31/14

	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	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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			212									212	1
2	Food Purchase	(11)		950									939	2
3	Housekeeping			711									711	3
4	Laundry													4
5	Heat and Other Utilities			1,603									1,603	5
6	Maintenance	(46,868)		6,615	11,398								(28,855)	6
7	Other (specify):*				1,081								1,081	7
8	**TOTAL General Services**	(46,879)		10,091	12,479								(24,309)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(615)						(1,116)					(1,730)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(615)						(1,116)					(1,730)	16
	C. General Administration													
17	Administrative	(2,350)	2,350	4,396	23,768								28,164	17
18	Directors Fees													18
19	Professional Services	(3,264)		(131,464)									(134,728)	19
20	Fees, Subscriptions & Promotions	(20,914)	250	2,335									(18,329)	20
21	Clerical & General Office Expenses	(92,841)	55	15,992	139,460								62,666	21
22	Employee Benefits & Payroll Taxes				(6,402)								(6,402)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(3,570)		366									(3,204)	24
25	Other Admin. Staff Transportation			1,795									1,795	25
26	Insurance-Prop.Liab.Malpractice			1,930									1,930	26
27	Other (specify):*				34,825								34,825	27
28	**TOTAL General Administration**	(122,939)	2,655	(104,650)	191,651								(33,283)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(170,433)	2,655	(94,559)	204,130			(1,116)					(59,323)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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	9,773	130,535	5,947									146,255	30
31	Amortization of Pre-Op. & Org.	(51,755)	51,755											31
32	Interest	(44,698)	562,570	1,361									519,233	32
33	Real Estate Taxes			3,466									3,466	33
34	Rent-Facility & Grounds		(936,000)										(936,000)	34
35	Rent-Equipment & Vehicles			1,055									1,055	35
36	Other (specify):*													36
37	TOTAL Ownership	(86,680)	(191,140)	11,829									(265,991)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(2,172)					(2,172)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(411,440)											(411,440)	43
44	TOTAL Special Cost Centers	(411,440)						(2,172)					(413,612)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(668,553)	(188,485)	(82,730)	204,130			(3,288)					(738,926)	45

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 6-Supplemental		See 6-Supplemental		See 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	$ 936,000	Sheridan Shores Property, LLC	100.00%	$	$ (936,000)	1
2	V	17	Management Fees		Sheridan Shores Property, LLC	100.00%	2,350	2,350	2
3	V	21	Bank Service Charges		Sheridan Shores Property, LLC	100.00%	55	55	3
4	V	20	Filing Fees		Sheridan Shores Property, LLC	100.00%	250	250	4
5	V	30	Depreciation		Sheridan Shores Property, LLC	100.00%	130,535	130,535	5
6	V	31	Amortization		Sheridan Shores Property, LLC	100.00%	51,755	51,755	6
7	V	32	Interest		Sheridan Shores Property, LLC	100.00%	562,570	562,570	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 936,000			$ 747,515	$ * (188,485)	14

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

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	$ 212	$ 212	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	950	950	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	711	711	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,603	1,603	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	6,615	6,615	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	4,396	4,396	20
21	V	19	Professional Fees	144,000	Extended Care Consulting, LLC	100.00%	12,536	(131,464)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	2,335	2,335	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	15,992	15,992	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	366	366	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,795	1,795	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,930	1,930	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	5,947	5,947	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	1,361	1,361	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	3,466	3,466	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,055	1,055	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			$ 144,000			$ 61,270	$ * (82,730)	39

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

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	11,398	$ 11,398	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%	1,081	1,081	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%	23,768	23,768	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	139,460	139,460	22
23	V	21	Office and Clerical (Direct)	21,339	Extended Care Consulting, LLC	100.00%	21,339		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	30,065	30,065	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	4,760	4,760	25
26	V	22	Employee Benefits	6,402	Extended Care Consulting, LLC	100.00%		(6,402)	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			$ 27,741			$ 231,871	$ * 204,130	39

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

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	$ 120,744	$ 120,744	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	120,744	CCS Employee Benefits Group	100.00%		(120,744)	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			$ 120,744			$ 120,744	$ *	39

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

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 1,115	Care Centers Health Systems, Inc.	100.00%	$ 1,115	$	15
16	V	39	Ancillary Expense	664	Care Centers Health Systems, Inc.	100.00%	664		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			$ 1,779			$ 1,779	$ *	39

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

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	10	Nursing Supplies / Nursing Equip. Rental	3,963	Reliable Medical of the Midwest, LLC	100.00%	2,847	$ (1,116)	15
16	V	39	Ancillary Expense	7,714	Reliable Medical of the Midwest, LLC	100.00%	5,542	(2,172)	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			$ 11,677			$ 8,389	$ * (3,288)	39

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

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	SHERIDAN SHORES PROPERTY	EVANSTON	BUILDING CO.	1
2	ERIC ROTHNER GRANTOR TRUST	29.787%	BRIAR PLACE LTD.	INDIAN HEAD PARK	EXTENDED CARE CONSULTING	EVANSTON	MANAGEMENT/BOOKKI	2
3	NATHAN & SHIRLEY ROTHNER FAMILY TR	54.255%	CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	CARE CENTER HEALTH SYSTE	DES PLAINES	DIETARY & FOOD SUPPI	3
4			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	4
5			GRASMERE PLACE, LLC	CHICAGO	CARE CENTERS BUILDING LLC	EVANSTON	BLDG COMPANY	5
6			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	RELIABLE MEDICAL OF THE M	DES PLAINES	MEDICAL SUPPLIES	6
7			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT				7
8			MAJOR HOSPITAL DYER	DYER, IN				8
9			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				9
10			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				10
11			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				11
12			MAJOR HOSPITAL SEBOS	HOBART, IN				12
13			MCKINLEY HEALTH CARE CENTER	CANTON, OH				13
14			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				14
15			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				15
16			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				16
17			RAINBOW BEACH QOC, L.L.C.	CHICAGO				17
18			SHEFFIELD MANOR	DYER, IN				18
19			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				19
20			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				20
21			ST. JAMES WELLNESS REHAB VILLAS	CRETE				21
22			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				22
23			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				23
24			WHEATON CARE CENTER	WHEATON				24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	3.86	7.02%	Al Sal/Al Fee	$ 14,015	17-7	1
2	Adam Vales	Relative	Clerical	0.00%	See Attached	1.04	2.60%	Alloc Salary	1,922	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	$ 15,937		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 Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	1,251,572	31	$ 4,057	$	65,496	$ 212	1
2	02	Food	Patient Days	1,251,572	31	18,150		65,496	950	2
3	03	Housekeeping	Patient Days	1,251,572	31	13,578		65,496	711	3
4	05	Utilities	Patient Days	1,251,572	31	30,626		65,496	1,603	4
5	06	Maintenance	Patient Days	1,251,572	31	126,400		65,496	6,615	5
6	17	Administrative	Patient Days	1,251,572	31	84,000		65,496	4,396	6
7	19	Professional Fees	Patient Days	1,251,572	31	239,560		65,496	12,536	7
8	20	Dues and Subscriptions	Patient Days	1,251,572	31	44,626		65,496	2,335	8
9	21	Office and Clerical	Patient Days	1,251,572	31	305,586		65,496	15,992	9
10	24	Seminar and Travel	Patient Days	1,251,572	31	6,989		65,496	366	10
11	25	Other Staff Admin. Trans.	Patient Days	1,251,572	31	34,307		65,496	1,795	11
12	26	Insurance	Patient Days	1,251,572	31	36,877		65,496	1,930	12
13	30	Depreciation	Patient Days	1,251,572	31	113,642		65,496	5,947	13
14	32	Interest	Patient Days	1,251,572	31	26,010		65,496	1,361	14
15	33	Real Estate Taxes	Patient Days	1,251,572	31	66,240		65,496	3,466	15
16	35	Rent - Equipment & Auto	Patient Days	1,251,572	31	20,168		65,496	1,055	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,170,816	$		$ 61,270	25

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	1,251,572	31	217,811	217,811	65,496	11,398	1
2	06	Maintenance (Direct)	Direct		31	252,781	252,781			2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,251,572	31	20,665		65,496	1,081	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	33,212				4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,251,572	31	454,189	454,189	65,496	23,768	7
8	21	Office and Clerical (Pooled)	Patient Days	1,251,572	31	2,664,951	2,664,951	65,496	139,460	8
9	21	Office and Clerical (Direct)	Direct		31	385,321	385,321		21,339	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,251,572	31	574,509		65,496	30,065	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	59,282			4,760	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					$ 4,662,721	$ 3,975,053		$ 231,871	25

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			$	$		$ 120,744	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					$	$		$ 120,744	25

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			$	$		$ 1,115	1
2	39	Ancillary Expense	Direct Allocation						664	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					$	$		$ 1,779	25

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	10	Nursing Supplies / Nursing Equip	Direct Allocation						2,847	1
2	39	Ancillary Expense	Direct Allocation						5,542	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					$	$		$ 8,389	25

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Bank Leumi		X	Mortgage			$	$ 11,157,353			$ 562,570	1
2												2
3												3
4												4
5												5
	Working Capital											
6	ECC	X		Note Payable - Dell				25,842				6
7	Shareholder Loan	X		Line of Credit				222,574				7
8												8
9	TOTAL Facility Related						$	$ 11,405,769			$ 562,570	9
	B. Non-Facility Related*											
10	Interest Income		X								(44,698)	10
11	Allocated from EC Consulting	X									1,361	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (43,337)	14
15	TOTALS (line 9+line14)						$	$ 11,405,769			$ 519,233	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.)**

**** 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 Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	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 Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 110,197	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.)		$ 230,216	2
3. Under or (over) accrual (line 2 minus line 1).		$ 120,019	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 113,375	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.		$ 233,394	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2009	165,293	8
2010	172,489	9
2011	171,772	10
2012	223,723	11
2013	226,750	12

2014 Accrual = $226,750 x 1.05 = $238,088 - 124,713 (2014 Tax Prepayment) = $113,375

Beginning Accrual Adjusted to reflect prior year's 2013 prepayment and this year's 2014 prepayment

Allocated from EC Consulting = $3,466

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sheridan Shores Cr & Reh Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040444

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(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	$ 113,375.20	$ 113,375.20
2.	14-05-402-028-0000	Long Term Care Property	$ 113,375.20	$ 113,375.20
3.	See Attached	Allocation From 2201 Main	$ 162,082.08	$ 3,301.38
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 388,832.48	$ 230,051.78

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 Cr & Reh Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040444

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 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 Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			16,702	2
3	TOTALS			$ 707,625	3

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 130,535	39	$ 114,007	$ (16,528)	$ 1,145,118	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	42,874		20			42,868	9
10	Various			1994	57,552		20	1,374	1,374	57,537	10
11	Various			1995	146,433		20	7,322	7,322	143,903	11
12	Various			1996	67,704		20	3,385	3,385	62,946	12
13	Various			1997	53,902		20	2,695	2,695	47,297	13
14	Various			1998	172,679		20	8,634	8,634	143,297	14
15	Various			1999	62,682		20	3,134	3,134	48,769	15
16	Various			2000	149,525		20	7,450	7,450	108,700	16
17	Various			2001	56,462		20	2,823	2,823	38,898	17
18	Various			2002	66,781		20	693	693	64,635	18
19	Various			2003	90,560		20			90,560	19
20	Various			2004	93,862		20	4,558	4,558	89,481	20
21	Various			2005	446,038		20	23,842	23,842	229,236	21
22	Various			2006	105,189		20	9,873	9,873	88,442	22
23	Various			2007	43,478		20	3,983	3,983	34,100	23
24	Various			2008	63,072		20	5,980	5,980	37,768	24
25	Various			2009	305,440		20	17,578	17,578	103,371	25
26	Various			2010	115,579		20	16,339	16,339	71,519	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 Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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)		552,570			27,629	27,629	52,879	67
68	Related Party Allocations (Pages 12H & 12I)		73,750	4,647		4,647		50,621	68
69	Financial Statement Depreciation			166,914			(166,914)		69
70	TOTAL (lines 4 thru 69)		$ 7,212,389	$ 302,096		$ 265,945	$ (36,151)	$ 2,751,946	70

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

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 7,212,389	$ 302,096		$ 265,945	$ (36,151)	$ 2,751,946	1
2	Installation Of New Rental Unit	2011	3,681		20	368	368	1,472	2
3	Sprinkler System Repair	2011	2,854		20	285	285	1,094	3
4	2 Automatic Transfer Switches	2011	5,156		20	1,031	1,031	3,867	4
5	New Parking Lot Beans & Slab	2011	18,900		20	945	945	3,465	5
6	Replace Doors, Fix Drywall & Tile	2011	5,014		20	501	501	1,838	6
7	Fire Damper Service	2011	5,634		20	563	563	2,019	7
8	Drywall	2011	3,500		20	350	350	1,254	8
9	Install Fire Dampers	2011	16,350		20	1,635	1,635	5,450	9
10	Satellite Cable Installation	2011	3,099		20	310	310	1,007	10
11	Garage Structure Repair	2011	32,500		20	3,250	3,250	10,292	11
12	Doors & Walls Installation	2012	10,850		20	1,085	1,085	3,255	12
13	Grids & Tiles Installation	2012	3,955		20	396	396	1,121	13
14	Supply & Exhaust-Ducting With Fire Dampers Installation	2012	4,850		20	485	485	1,374	14
15	Control Valve Replacement	2012	4,430		20	443	443	1,181	15
16	Flooring	2012	12,400		20	1,240	1,240	3,100	16
17	Security Camera System	2012	3,895		20	779	779	1,948	17
18	3 New Volt Circuits & Outlets	2012	2,950		20	295	295	713	18
19	Storage Tank	2012	6,364		20	636	636	1,538	19
20	Fire Dampers & Exhaust Fan	2012	2,653		20	265	265	597	20
21	Basement Compressor & Electrical Work	2012	6,244		20	624	624	1,405	21
22	Replace Copper Piping Accross Basement Ceiling	2012	9,300		20	465	465	969	22
23	Smoke Damper Repairs	2012	4,612		20	231	231	557	23
24	Wiring - Generator To Control	2012	7,000		20	350	350	875	24
25	Install Hot Water Pump	2012	2,706		20	135	135	327	25
26	Repair West Elevation Steel Door	2012	2,695		20	135	135	348	26
27	Wander Security System	2013	8,814		20	881	881	1,616	27
28	Install Ceiling Fans In 1St Floor Lounge	2013	11,731		20	1,173	1,173	2,151	28
29	Furnish & Install Floorfolio In Day Room	2013	5,000		20	500	500	917	29
30	Install Fire Alarm Boxes In Elevators	2013	5,335		20	534	534	889	30
31	Install Stair Rods & Steel Bars On Rail System	2013	3,230		20	323	323	511	31
32	Provide & Install 2 New Fan/Coil Air Conditioners In Securtiy, Re	2013	6,200		20	620	620	878	32
33	Recover The Entire Canopy & Wall System On Front Patio	2013	10,400		20	1,040	1,040	1,387	33
34	TOTAL (lines 1 thru 33)		$ 7,444,688	$ 302,096		$ 287,820	$ (14,276)	$ 2,811,360	34

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

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 7,444,688	$ 302,096		$ 287,820	$ (14,276)	$ 2,811,360	1
2	Repair Leaking Drain Line	2014	2,868		20	263	263	263	2
3	Removed & Installed Rebuilt Sewage Pump	2014	3,695		20	277	277	277	3
4	South & North Stairwell Fire Protection	2014	22,452		20	1,497	1,497	1,497	4
5	Emergency Generator	2014	67,670		20	1,692	1,692	1,692	5
6	Water Heater	2014	16,992		20	142	142	142	6
7	Pt Room And Hallways - Metal Frames, Outlets, Lights And Dryw	2014	6,800		20	28	28	28	7
8	Indoor & Outdoor Bells, Basement Tamper	2014	2,867		20	143	143	143	8
9	Replace Sprinkler System Heads	2014	5,011		20	251	251	251	9
10	Elevator Transmitter & Receiver Units	2014	3,450		20	173	173	173	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)		$ 7,576,494	$ 302,096		$ 292,285	$ (9,811)	$ 2,815,825	34

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

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 7,576,494	$ 302,096		$ 292,285	$ (9,811)	$ 2,815,825	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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)		$ 7,576,494	$ 302,096		$ 292,285	$ (9,811)	$ 2,815,825	34

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

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 7,576,494	$ 302,096		$ 292,285	$ (9,811)	$ 2,815,825	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)		$ 7,576,494	$ 302,096		$ 292,285	$ (9,811)	$ 2,815,825	34

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

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12E, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9									9
10	Tuckpointing	2013	505,000		20	25,250	25,250	50,500	10
11	Resurface Parking Deck	2014	47,570		20	2,379	2,379	2,379	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)		$ 552,570	$		$ 27,629	$ 27,629	$ 52,879	34

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

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12F, Carried Forward		$ 552,570	$		$ 27,629	$ 27,629	$ 52,879	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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)		$ 552,570	$		$ 27,629	$ 27,629	$ 52,879	34

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

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3	Allocated From Extended Care Consulting 2201 Main LLC	2002	23,016	590	39	590		7,254	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated From Extended Care Consulting	2007	241	12	20	12		96	9
10	Allocated From Extended Care Consulting	2009	144	7	20	7		43	10
11	Allocated From Extended Care Consulting	2010	1,412	71	20	71		353	11
12	Allocated From Extended Care Consulting	2011	508	25	20	25		102	12
13	Allocated From Extended Care Consulting	2012	167	8	20	8		25	13
14	Allocated From Extended Care Consulting	2014	2,321	116	20	116		116	14
15									15
16	Allocated From Extended Care Consulting 2201 Main LLC	2002	19,013	1,620	20	1,620		19,013	16
17	Allocated From Extended Care Consulting 2201 Main LLC	2003	22,406	1,910	20	1,910		22,406	17
18	Allocated From Extended Care Consulting 2201 Main LLC	2005	1,113	118	20	118		993	18
19	Allocated From Extended Care Consulting 2201 Main LLC	2009	201	10	20	10		60	19
20	Allocated From Extended Care Consulting 2201 Main LLC	2014	3,208	160	20	160		160	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)		$ 73,750	$ 4,647		$ 4,647	$	$ 50,621	34

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

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12H, Carried Forward		$ 73,750	$ 4,647		$ 4,647	$	$ 50,621	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
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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)		$ 73,750	$ 4,647		$ 4,647	$	$ 50,621	34

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

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 343,405	$ 644	$ 16,054	$ 15,410	10	$ 300,730	71
72	Current Year Purchases	57,721	387	4,562	4,175	10	4,562	72
73	Fully Depreciated Assets	1,120,760				10	1,120,760	73
74								74
75	TOTALS	$ 1,521,886	$ 1,031	$ 20,615	$ 19,584		$ 1,426,051	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	2014	$ 9,444	$ 267	$ 267	$	5	$ 8,377	76
77										77
78										78
79										79
80	TOTALS			$ 9,444	$ 267	$ 267	$		$ 8,377	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)	$ 9,815,450	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 303,394	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 313,167	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 9,773	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,250,253	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 Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 6,698 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	$	$ 15,074	17
18	Enterprise Rent a Car			451	18
19					19
20					20
21	TOTAL		$	$ 15,525	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.

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$		$ 318,265	$		$ 318,265	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			7,663			7,663	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			343,260			343,260	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				223,014		223,014	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						72,588		72,588	13
14	TOTAL			$		$ 669,188	$ 295,602		$ 964,790	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.

STATE OF ILLINOIS

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/14 (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	$ 107,408	$ 393,701	1
2	Cash-Patient Deposits	37,162	37,162	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,144,422	1,144,422	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	241,170	241,170	6
7	Other Prepaid Expenses	1,327	1,327	7
8	Accounts Receivable (owners or related parties)		7,327,976	8
9	Other(specify):	2,688,882	2,840,434	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,220,371	$ 11,986,192	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		4,894,437	14
15	Leasehold Improvements, at Historical Cost	2,284,108	2,383,497	15
16	Equipment, at Historical Cost	991,163	1,578,447	16
17	Accumulated Depreciation (book methods)	(2,639,460)	(4,317,633)	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):	4,145,537	4,444,483	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,781,348	$ 9,674,154	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,001,719	$ 21,660,346	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 6,464,367	$ 6,464,366	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	37,763	37,763	28
29	Short-Term Notes Payable	25,842	25,842	29
30	Accrued Salaries Payable	298,416	298,416	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,891	11,891	31
32	Accrued Real Estate Taxes(Sch.IX-B)	113,375	113,375	32
33	Accrued Interest Payable	123,254	170,332	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	173,773	173,773	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,248,681	$ 7,295,758	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	222,574	222,574	39
40	Mortgage Payable		11,157,354	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 222,574	$ 11,379,928	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,471,255	$ 18,675,686	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,530,464	$ 2,984,660	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,001,719	$ 21,660,346	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 906,132	1	
2	Restatements (describe):		2	
3	**Prior year bad debt**	28,802	3	
4	**Prior year dividend adjustment**	(500,000)	4	
5	**Rounding**	8	5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 434,942	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,095,522	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)**	$ 1,095,522	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,530,464	24	*

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

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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	$ 11,263,914	1
2	Discounts and Allowances for all Levels	(2,740,095)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,523,819	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,725,712	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,725,712	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	230,462	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,598	19
20	Radiology and X-Ray	290	20
21	Other Medical Services	3,030	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 242,380	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	44,698	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 44,698	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	17	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 17	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,536,626	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,754,841	31
32	Health Care	3,598,919	32
33	General Administration	1,881,190	33
	B. Capital Expense		
34	Ownership	1,354,011	34
	C. Ancillary Expense		
35	Special Cost Centers	1,376,230	35
36	Provider Participation Fee	475,913	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,441,104	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,095,522	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,095,522	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,799,305	44
45	Private Pay - Net Inpatient Revenue	31,917	45
46	Medicare - Net Inpatient Revenue	(370,364)	46
47	Other-(specify) Hospice	380	47
48	Other-(specify) Insurance	62,581	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,523,819	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.**

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,854	1,950	$ 99,627	$ 51.09	1
2	Assistant Director of Nursing	1,800	1,902	69,294	36.43	2
3	Registered Nurses	15,281	17,402	564,755	32.45	3
4	Licensed Practical Nurses	36,853	40,200	982,091	24.43	4
5	CNAs & Orderlies	81,392	90,006	1,018,810	11.32	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,661	9,570	140,070	14.64	8
9	Activity Director	1,937	2,251	34,658	15.40	9
10	Activity Assistants	7,842	8,607	88,617	10.30	10
11	Social Service Workers	17,605	19,031	374,862	19.70	11
12	Dietician					12
13	Food Service Supervisor	2,073	2,115	40,895	19.34	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,353	6,945	88,616	12.76	15
16	Dishwashers	12,843	14,722	144,574	9.82	16
17	Maintenance Workers	13,941	14,761	190,665	12.92	17
18	Housekeepers	19,831	21,822	213,023	9.76	18
19	Laundry	9,421	10,110	105,610	10.45	19
20	Administrator	2,116	2,339	135,561	57.96	20
21	Assistant Administrator	2,039	2,197	36,839	16.77	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,227	7,023	92,104	13.11	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	1,697	1,919	23,041	12.01	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	7,512	7,954	351,440	44.18	33
34	TOTAL (lines 1 - 33)	257,278	282,826	$ 4,795,152 *	$ 16.95	34

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

** See instructions.

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	270	$ 13,162	01-03	35
36	Medical Director	Monthly	3,600	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	11,753	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	23,000	12-03	45
46	Other(specify)				46
47	Psychiatrist Consultant	Monthly	24,900	10-03	47
48					48
49	TOTAL (lines 35 - 48)	270	$ 76,415		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kayla Moore	Adminstrator	0	$ 135,561
Shloimy Langsner	AIT	0	36,839
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 172,400

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 25,700
Extended Care Consulting	Home Office Expense	144,000
Personnel Planners	Unemployment Consultant	2,203
Pro Payroll Solutions	Payroll Processing	26,970
E-Health Data Solutions	MDS Software	2,385
AIS Assessment & Intelligence	MDS Consultant	1,329
Ability Network	Medicare Billing	2,752
National Datacare Corporation	Resident Fund Processing	2,648
Shawn Truhlar	Website Design	330
Navex Global	Compliance	237
Online MSDS	MSDS Management	571
See Supplemental Schedule		86,178
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 295,302

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 109,617
Unemployment Compensation Insurance	90,766
FICA Taxes	360,389
Employee Health Insurance	206,676
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	3,424
Pension Expense	39,357
Other Employee Welfare	14,379
Holiday Expense	3,679
TOTAL (agree to Schedule V, line 22, col.8)	$ 828,287

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	4,552
Health Care Worker Background Check	
(Indicate # of checks performed 139)	3,659
Patient Background Checks	
Dues & Subscriptions	17,116
Licenses & Fees	3,564
Allocated from EC Consulting	2,335
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 33,215

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,893
Allocated from EC Consulting	366
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,259

**See instructions.

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$		$	$	$	$	$	$	$	$	$

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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. **ICLTC $19,482**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **17,405** 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. $ **475,913**
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? **Yes**
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 out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.