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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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) 282-6300
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 01/01/15 to 12/31/15 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)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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: 01/01/15 Ending: 12/31/15

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		584	2,700	3,284	8
9	SNF/PED					9
10	ICF	61,316			61,316	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	61,316	584	2,700	64,600	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.66%

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 2,478

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: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	283,010	49,258	14,247	346,515		346,515	214	346,729			1
2	Food Purchase		373,934		373,934		373,934	535	374,469			2
3	Housekeeping	242,386	50,833		293,219		293,219	1,502	294,721			3
4	Laundry	112,823	19,472		132,295		132,295		132,295			4
5	Heat and Other Utilities			203,805	203,805		203,805	2,276	206,081			5
6	Maintenance	207,513	76	224,497	432,086		432,086	19,605	451,691			6
7	Other (specify):*							1,124	1,124			7
8	**TOTAL General Services**	845,732	493,573	442,549	1,781,854		1,781,854	25,256	1,807,110			8
	B. Health Care and Programs											
9	Medical Director			3,500	3,500		3,500		3,500			9
10	Nursing and Medical Records	3,070,097	180,969	36,018	3,287,084		3,287,084	(3,918)	3,283,166			10
10a	Therapy	138,819			138,819		138,819		138,819			10a
11	Activities	126,180	21,929		148,109		148,109		148,109			11
12	Social Services	274,949	4,835	37,460	317,244		317,244		317,244			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,610,045	207,733	76,978	3,894,756		3,894,756	(3,918)	3,890,838			16
	C. General Administration											
17	Administrative	135,319			135,319		135,319	26,988	162,307			17
18	Directors Fees											18
19	Professional Services			354,516	354,516	(5,500)	349,016	(166,903)	182,113			19
20	Dues, Fees, Subscriptions & Promotions			58,982	58,982		58,982	(16,065)	42,917			20
21	Clerical & General Office Expenses	100,620	36,266	258,619	395,505		395,505	(10,910)	384,595			21
22	Employee Benefits & Payroll Taxes			825,830	825,830		825,830	(6,706)	819,124			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,755	4,755		4,755	1,501	6,256			24
25	Other Admin. Staff Transportation			8,854	8,854		8,854	1,835	10,689			25
26	Insurance-Prop.Liab.Malpractice			206,175	206,175		206,175	1,872	208,047			26
27	Other (specify):*							32,409	32,409			27
28	**TOTAL General Administration**	235,939	36,266	1,717,731	1,989,936	(5,500)	1,984,436	(135,979)	1,848,457			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,691,716	737,572	2,237,258	7,666,546	(5,500)	7,661,046	(114,641)	7,546,405			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: 01/01/15 Ending: 12/31/15

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			127,479	127,479		127,479	175,010	302,489			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			359	359		359	498,584	498,943			32
33	Real Estate Taxes			236,114	236,114	5,500	241,614	5,981	247,595			33
34	Rent-Facility & Grounds			936,000	936,000		936,000	(936,000)				34
35	Rent-Equipment & Vehicles			21,800	21,800		21,800	(4,905)	16,895			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,321,752	1,321,752	5,500	1,327,252	(261,330)	1,065,922			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		108,316	371,721	480,037		480,037	(496)	479,541			39
40	Barber and Beauty Shops			122	122		122		122			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			481,793	481,793		481,793		481,793			42
43	Other (specify):*	291,811		60,000	351,811		351,811	(351,811)	(0)			43
44	**TOTAL Special Cost Centers**	291,811	108,316	913,636	1,313,763		1,313,763	(352,307)	961,456			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,983,527	845,888	4,472,646	10,302,061		10,302,061	(728,279)	9,573,782			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: 01/01/15 Ending: 12/31/15

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	(11,647)	30		9
10	Interest and Other Investment Income	(57,501)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(34)	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	(5,000)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(162,341)	21		24
25	Fund Raising, Advertising and Promotional	(3,699)	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	(461,359)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (701,581)		$	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)	(26,697)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (26,697)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (728,279)		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: **01/01/15**

Ending: **12/31/15**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Allowable Auto Lease	$ (6,000)	35	1
2	Jury Duty	(25)	10	2
3	Patient Clothing	(1,605)	10	3
4	Collection Expense	(2,448)	21	4
5	Veterans Expense	(30)	10	5
6	PAC Dues	(8,707)	20	6
7	Non-Allowable Fees	(60,000)	43	7
8	Lobbying	(1,060)	19	8
9	Building Company - Management Fees	(9,400)	17	9
10	Building Company - Bank Service Charges	(233)	21	10
11	Building Company - Filing Fees	(250)	21	11
12	Building Company - Amortization	(51,755)	36	12
13	Non-allowable Compensation	(291,811)	43	13
14	Seminar Expense	1,040	24	14
15	Non-Allowable Legal Fees	(29,075)	19	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(461,359)		49

Sheridan Shores Cr & Reh Ctr

ID# 0040444

Report Period Beginning: 01/01/15

Ending: 12/31/15

	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			49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr **#** 0040444 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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			214									214	1
2	Food Purchase	(34)		569									535	2
3	Housekeeping			1,502									1,502	3
4	Laundry													4
5	Heat and Other Utilities			2,276									2,276	5
6	Maintenance			6,549	13,056								19,605	6
7	Other (specify):*				1,124								1,124	7
8	**TOTAL General Services**	(34)		11,110	14,180								25,256	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,660)					(220)	(2,038)					(3,918)	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**	(1,660)					(220)	(2,038)					(3,918)	16
	C. General Administration													
17	Administrative	(9,400)	9,400	4,092	22,896								26,988	17
18	Directors Fees													18
19	Professional Services	(30,135)		(136,768)									(166,903)	19
20	Fees, Subscriptions & Promotions	(17,406)		1,341									(16,065)	20
21	Clerical & General Office Expenses	(165,272)	483	16,751	137,128								(10,910)	21
22	Employee Benefits & Payroll Taxes				(6,706)								(6,706)	22
23	Inservice Training & Education													23
24	Travel and Seminar	1,040		461									1,501	24
25	Other Admin. Staff Transportation			1,835									1,835	25
26	Insurance-Prop.Liab.Malpractice			1,872									1,872	26
27	Other (specify):*				32,409								32,409	27
28	**TOTAL General Administration**	(221,173)	9,883	(110,416)	185,727								(135,979)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(222,867)	9,883	(99,306)	199,907		(220)	(2,038)					(114,641)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	(11,647)	183,690	2,967									175,010	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(57,501)	544,151	11,934									498,584	32
33	Real Estate Taxes			5,981									5,981	33
34	Rent-Facility & Grounds		(936,000)										(936,000)	34
35	Rent-Equipment & Vehicles	(6,000)		1,095									(4,905)	35
36	Other (specify):*	(51,755)	51,755											36
37	**TOTAL Ownership**	(126,903)	(156,404)	21,977									(261,330)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(496)						(496)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(351,811)											(351,811)	43
44	**TOTAL Special Cost Centers**	(351,811)					(496)						(352,307)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(701,581)	(146,521)	(77,329)	199,907		(716)	(2,038)					(728,279)	45

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 936,000	Sheridan Shores Property, LLC	100.00%	$	$ (936,000)	1
2	V	17	Management Fees		Sheridan Shores Property, LLC	100.00%	9,400	9,400	2
3	V	21	Bank Service Charges		Sheridan Shores Property, LLC	100.00%	233	233	3
4	V	21	Filing Fees		Sheridan Shores Property, LLC	100.00%	250	250	4
5	V	30	Depreciation Expense		Sheridan Shores Property, LLC	100.00%	183,690	183,690	5
6	V	36	Amortization Expense		Sheridan Shores Property, LLC	100.00%	51,755	51,755	6
7	V	32	Interest Expense		Sheridan Shores Property, LLC	100.00%	544,151	544,151	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 936,000			$ 789,479	$ * (146,521)	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: 01/01/15 Ending: 12/31/15

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%	$ 214	$ 214	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	569	569	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	1,502	1,502	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	2,276	2,276	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	6,549	6,549	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	4,092	4,092	20
21	V	19	Professional Fees	144,000	Extended Care Consulting, LLC	100.00%	7,232	(136,768)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,341	1,341	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	16,751	16,751	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	461	461	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,835	1,835	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,872	1,872	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	2,967	2,967	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	11,934	11,934	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	5,981	5,981	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,095	1,095	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			$ 66,671	$ * (77,329)	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: 01/01/15 Ending: 12/31/15

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%	13,056	$ 13,056	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%	1,124	1,124	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%	22,896	22,896	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	137,128	137,128	22
23	V	21	Office and Clerical (Direct)	22,357	Extended Care Consulting, LLC	100.00%	22,357		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	27,471	27,471	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	4,938	4,938	25
26	V	22	Employee Benefits	6,706	Extended Care Consulting, LLC	100.00%		(6,706)	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			$ 29,063			$ 228,970	$ * 199,907	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: 01/01/15 Ending: 12/31/15

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%	$ 148,401	$ 148,401	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	148,401	CCS Employee Benefits Group	100.00%		(148,401)	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			$ 148,401			$ 148,401	$ *	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: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	$ 16,649	MAC Rx, LLC	100.00%	$ 16,429	$ (220)	15
16	V	39	Ancillary	37,569	MAC Rx, LLC	100.00%	37,073	(496)	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			$ 54,218			$ 53,502	$ * (716)	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: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing Supplies / Nursing Equip. Rental	7,239	Reliable Medical of the Midwest, LLC	100.00%	5,200	$ (2,038)	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			$ 7,239			$ 5,200	$ * (2,038)	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: 01/01/15 Ending: 12/31/15

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			$			$	$	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: 01/01/15 Ending: 12/31/15

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			$			$	$	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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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	15.96%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	SHERIDAN SHORES PROPERTY	EVANSTON	BUILDING CO.	1
2	ERIC ROTHNER GRANTOR TRUST	29.79%	BRIAR PLACE LTD.	INDIAN HEAD PARK	EXTENDED CARE CONSULTING	EVANSTON	MANAGEMENT/BOOKKEEP	2
3	NATHAN & SHIRLEY ROTHNER FAMILY TRUST	54.26%	CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CLINICAL	EVANSTON	CLINICAL	3
4			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	CARE CENTERS BUILDING	EVANSTON	BUILDING CO.	4
5			GRASMERE PLACE, LLC	CHICAGO	VENT LEASE LLC	EVANSTON	VENTILATOR EQUIPMENT	5
6			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	TRI CARE REHAB	HILLSIDE	THERAPY	6
7			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	7
8			MAJOR HOSPITAL DYER	DYER, IN	MAC RX	DES PLAINES	PHARMACY	8
9			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN	RELIABLE MEDICAL SUPPLY	DES PLAINES	MEDICAL SUPPLIES	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			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				19
20			SPRING CREEK NURSING & REHAB CENTER	JOLIET				20
21			ST. JAMES WELLNESS REHAB VILLAS	CRETE				21
22			THE ESTATES OF HYDE PARK	CHICAGO				22
23			THE PARC AT JOLIET	JOLIET				23
24			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				24
25			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				25
26			WHEATON CARE CENTER	WHEATON				26
27								27
28								28
29								29
30								30

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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%	See Attached	3.72	6.76%	Alloc Sal/Fee	$ 13,772	17-7	1
2	Adam Vales	Relative	Clerical	0%	See Attached	0.94	2.35%	Alloc Salary	1,592	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	$ 15,364		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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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	1,326,152	31	$ 4,390	$	64,600	$ 214	1
2	02	Food	Patient Days	1,326,152	31	11,689		64,600	569	2
3	03	Housekeeping	Patient Days	1,326,152	31	30,827		64,600	1,502	3
4	05	Utilities	Patient Days	1,326,152	31	46,718		64,600	2,276	4
5	06	Maintenance	Patient Days	1,326,152	31	134,435		64,600	6,549	5
6	17	Administrative	Patient Days	1,326,152	31	84,000		64,600	4,092	6
7	19	Professional Fees	Patient Days	1,326,152	31	148,456		64,600	7,232	7
8	20	Dues and Subscriptions	Patient Days	1,326,152	31	27,539		64,600	1,341	8
9	21	Office and Clerical	Patient Days	1,326,152	31	343,869		64,600	16,751	9
10	24	Seminar and Travel	Patient Days	1,326,152	31	9,455		64,600	461	10
11	25	Other Staff Admin. Trans.	Patient Days	1,326,152	31	37,668		64,600	1,835	11
12	26	Insurance	Patient Days	1,326,152	31	38,431		64,600	1,872	12
13	30	Depreciation	Patient Days	1,326,152	31	60,912		64,600	2,967	13
14	32	Interest	Patient Days	1,326,152	31	244,990		64,600	11,934	14
15	33	Real Estate Taxes	Patient Days	1,326,152	31	122,786		64,600	5,981	15
16	35	Rent - Equipment & Auto	Patient Days	1,326,152	31	22,475		64,600	1,095	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,368,640	$		$ 66,671	25

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	1,326,152	31	268,019	268,019	64,600	13,056	1
2	06	Maintenance (Direct)	Direct		31	325,218	325,218			2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,326,152	31	23,065		64,600	1,124	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	38,919				4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,326,152	31	470,018	470,018	64,600	22,896	7
8	21	Office and Clerical (Pooled)	Patient Days	1,326,152	31	2,815,061	2,815,061	64,600	137,128	8
9	21	Office and Clerical (Direct)	Direct		31	402,441	402,441		22,357	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,326,152	31	563,937		64,600	27,471	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	58,253			4,938	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					$ 4,964,932	$ 4,280,758		$ 228,970	25

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			$	$		$ 148,401	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					$	$		$ 148,401	25

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: MAC Rx, LLC
Street Address: 2307 S. Mount Prospect Road
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (224)220-2700
Fax Number: (224)220-2730

	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 And Medical Records	Direct Allocation			$	$		$ 16,429	1
2	39	Ancillary	Direct Allocation						37,073	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					$	$		$ 53,502	25

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/15 Ending: 12/31/15

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						5,200	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					$	$		$ 5,200	25

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/15 Ending: 12/31/15

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
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: 01/01/15 Ending: 12/31/15

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
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: 01/01/15 Ending: 12/31/15

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
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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bank Leumi		X	Mortgage			$	$ 10,778,374			$ 544,151	1
2												2
3												3
4												4
5												5
	Working Capital											
6	ECC	X		Note Payable - Dell				26,417				6
7	Shareholder Loan	X		Line of Credit				222,574				7
8												8
9	TOTAL Facility Related						$	$ 11,027,365			$ 544,151	9
	B. Non-Facility Related*											
10	Interest Income		X								(57,501)	10
11	Interest Expense		X								359	11
12	Allocated - EC Consulting	X									11,934	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (45,208)	14
15	TOTALS (line 9+line14)						$	$ 11,027,365			$ 498,943	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: 01/01/15 Ending: 12/31/15

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 238,088	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.)		$ 237,299	2
3. Under or (over) accrual (line 2 minus line 1).		$ (789)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 242,884	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.**		$ 5,500	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 247,595	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	172,489	8
	2011	171,772	9
	2012	223,723	10
	2013	226,750	11
	2014	231,318	12

2015 Accrual = $231,318 x 1.05 = $242,884

The beginning accrual was adjusted to account for the payment of the 1st installment of the tax bills in 2014

Allocated from Extended Care Consulting = $5,981

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 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 2014 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 2014.

	(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	$ 115,659.07	$ 115,659.07
2.	14-05-402-028-0000	Long Term Care Property	$ 115,659.07	$ 115,659.07
3.	See Attached	Allocated from 2201 Main	$ 165,913.23	$ 5,656.01
4.	See Attached	Allocated from 502 Main	$ 3,814.66	$ 185.82
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 401,046.03	$ 237,159.97

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 01/01/15 Ending: 12/31/15

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 Extended Care Consulting 2201 Main LLC			27,954	2
3	TOTALS			$ 718,877	3

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 183,690	39	$ 114,007	$ (69,683)	$ 1,259,125	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			57,537	10
11	Various			1995	146,433		20	2,519	2,519	146,422	11
12	Various			1996	67,704		20	3,384	3,384	66,329	12
13	Various			1997	53,902		20	2,695	2,695	49,992	13
14	Various			1998	172,679		20	8,634	8,634	151,931	14
15	Various			1999	62,682		20	3,134	3,134	51,903	15
16	Various			2000	149,525		20	7,450	7,450	116,150	16
17	Various			2001	56,462		20	2,823	2,823	41,721	17
18	Various			2002	66,781		20	444	444	65,079	18
19	Various			2003	90,560		20			90,560	19
20	Various			2004	93,862		20	736	736	90,216	20
21	Various			2005	446,038		20	21,572	21,572	250,808	21
22	Various			2006	105,189		20	9,873	9,873	98,315	22
23	Various			2007	43,478		20	3,682	3,682	37,782	23
24	Various			2008	63,072		20	5,980	5,980	43,748	24
25	Various			2009	305,440		20	16,059	16,059	119,430	25
26	Various			2010	115,579		20	14,530	14,530	86,049	26
27	Various			2011	96,687		20	9,239	9,239	40,998	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: 01/01/15 Ending: 12/31/15

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	80,508	67
68	Related Party Allocations (Pages 12H & 12I)		118,162	1,609		1,609		85,676	68
69	Financial Statement Depreciation			127,479			(127,479)		69
70	TOTAL (lines 4 thru 69)		$ 7,353,488	$ 312,778		$ 255,999	$ (56,780)	$ 3,073,149	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: 01/01/15 Ending: 12/31/15

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		$ 7,353,488	$ 312,778		$ 255,999	$ (56,780)	$ 3,073,149	1
2	Doors & Walls Installation	2012	10,850		20	1,085	1,085	4,340	2
3	Grids & Tiles Installation	2012	3,955		20	396	396	1,516	3
4	Supply & Exhaust-Ducting With Fire Dampers Installation	2012	4,850		20	485	485	1,859	4
5	Control Valve Replacement	2012	4,430		20	443	443	1,624	5
6	Flooring	2012	12,400		20	1,240	1,240	4,340	6
7	Security Camera System	2012	3,895		20	779	779	2,727	7
8	3 New Volt Circuits & Outlets	2012	2,950		20	295	295	1,008	8
9	Storage Tank	2012	6,364		20	636	636	2,174	9
10	Fire Dampers & Exhaust Fan	2012	2,653		20	265	265	862	10
11	Basement Compressor & Electrical Work	2012	6,244		20	624	624	2,029	11
12	Replace Copper Piping Accross Basement Ceiling	2012	9,300		20	465	465	1,434	12
13	Smoke Damper Repairs	2012	4,612		20	231	231	788	13
14	Wiring - Generator To Control	2012	7,000		20	350	350	1,225	14
15	Install Hot Water Pump	2012	2,706		20	135	135	462	15
16	Repair West Elevation Steel Door	2012	2,695		20	135	135	483	16
17	Wander Security System	2013	8,814		20	881	881	2,497	17
18	Install Ceiling Fans In 1St Floor Lounge	2013	11,731		20	1,173	1,173	3,324	18
19	Furnish & Install Floorfolio In Day Room	2013	5,000		20	500	500	1,417	19
20	Install Fire Alarm Boxes In Elevators	2013	5,335		20	534	534	1,423	20
21	Install Stair Rods & Steel Bars On Rail System	2013	3,230		20	323	323	834	21
22	Provide & Install 2 New Fan/Coil Air Conditioners In Securtiy, Re	2013	6,200		20	620	620	1,498	22
23	Recover The Entire Canopy & Wall System On Front Patio	2013	10,400		20	1,040	1,040	2,427	23
24	Repair Leaking Drain Line	2014	2,868		20	287	287	550	24
25	Removed & Installed Rebuilt Sewage Pump	2014	3,695		20	370	370	647	25
26	South & North Stairwell Fire Protection	2014	22,452		20	2,245	2,245	3,742	26
27	Emergency Generator	2014	67,670		20	3,384	3,384	5,075	27
28	Water Heater	2014	16,992		20	850	850	991	28
29	Pt Room & Hallway - Metal Frames, Outlets, Lights, Drywall	2014	6,800		20	340	340	368	29
30	Indoor & Outdoor Bells, Basement Tamper	2014	2,867		20	143	143	287	30
31	Replace Sprinkler System Heads	2014	5,011		20	251	251	480	31
32	Elevator Transmitter & Receiver Units	2014	3,450		20	173	173	302	32
33	Boiler Repair - New Tubes & Gaskets	2015	4,098		20	120	120	120	33
34	TOTAL (lines 1 thru 33)		$ 7,625,004	$ 312,778		$ 276,795	$ (35,984)	$ 3,126,002	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: 01/01/15 Ending: 12/31/15

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		$ 7,625,004	$ 312,778		$ 276,795	$ (35,984)	$ 3,126,002	1
2	New Barrel For Parking Door	2015	4,527		20	57	57	57	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
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18									18
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,629,531	$ 312,778		$ 276,851	$ (35,927)	$ 3,126,059	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: 01/01/15 Ending: 12/31/15

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		$ 7,629,531	$ 312,778		$ 276,851	$ (35,927)	$ 3,126,059	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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22									22
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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)		$ 7,629,531	$ 312,778		$ 276,851	$ (35,927)	$ 3,126,059	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: 01/01/15 Ending: 12/31/15

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		$ 7,629,531	$ 312,778		$ 276,851	$ (35,927)	$ 3,126,059	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)		$ 7,629,531	$ 312,778		$ 276,851	$ (35,927)	$ 3,126,059	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: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Tuckpointing	2013	505,000		20	25,250	25,250	75,750	9
10	Resurface Parking Deck	2014	47,570		20	2,379	2,379	4,758	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)		$ 552,570	$		$ 27,629	$ 27,629	$ 80,508	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: 01/01/15 Ending: 12/31/15

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	$ 80,508	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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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	$ 80,508	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: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Extended Care Consulting 2201 Main LLC	2002	38,522	988	39	988		13,129	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting	2007	224	11	20	11		101	9
10	Allocated from Extended Care Consulting	2009	134	7	20	7		47	10
11	Allocated from Extended Care Consulting	2010	1,314	66	20	66		394	11
12	Allocated from Extended Care Consulting	2011	473	24	20	24		118	12
13	Allocated from Extended Care Consulting	2012	156	8	20	8		31	13
14	Allocated from Extended Care Consulting	2014	2,160	108	20	108		216	14
15									15
16	Allocated from Extended Care Consulting 2201 Main LLC	2002	31,822		20			31,822	16
17	Allocated from Extended Care Consulting 2201 Main LLC	2003	37,501		20			37,501	17
18	Allocated from Extended Care Consulting 2201 Main LLC	2005	1,863	198	20	198		1,860	18
19	Allocated from Extended Care Consulting 2201 Main LLC	2009	336	17	20	17		118	19
20	Allocated from Extended Care Consulting 2201 Main LLC	2014	3,127	156	20	156		313	20
21	Allocated from Extended Care Consulting 2201 Main LLC	2015	530	26	20	26		26	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)		$ 118,162	$ 1,609		$ 1,609	$	$ 85,676	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: 01/01/15 Ending: 12/31/15

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		$ 118,162	$ 1,609		$ 1,609	$	$ 85,676	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 118,162	$ 1,609		$ 1,609	$	$ 85,676	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: 01/01/15 Ending: 12/31/15

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	$ 392,167	$ 960	$ 25,240	$ 24,280	10	$ 322,026	71
72	Current Year Purchases	1,501	150	150		10	150	72
73	Fully Depreciated Assets	1,123,042				10	1,123,042	73
74								74
75	TOTALS	$ 1,516,710	$ 1,110	$ 25,390	$ 24,280		$ 1,445,218	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	2015	$ 8,791	$ 248	$ 248	$	5	$ 8,046	76
77										77
78										78
79										79
80	TOTALS			$ 8,791	$ 248	$ 248	$		$ 8,046	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)	$ 9,873,910	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 314,136	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 302,489	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (11,647)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,579,323	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: 01/01/15 Ending: 12/31/15

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 5,905 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	$ 915.83	$ 10,990	17
18					18
19					19
20					20
21	TOTAL		$ 915.83	$ 10,990	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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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	$		$ 166,323	$		$ 166,323	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			16,614			16,614	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			188,784			188,784	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				84,470		84,470	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						23,846		23,846	13
14	TOTAL			$		$ 371,721	$ 108,316		$ 480,037	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:** 01/01/15 **Ending:** 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/15 **(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	$ 124,140	$ 488,159	1
2	Cash-Patient Deposits	57,294	57,294	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	337,508	337,508	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	240,221	240,221	6
7	Other Prepaid Expenses	9,014	9,014	7
8	Accounts Receivable (owners or related parties)		6,565,032	8
9	Other(specify):	3,876,791	3,876,791	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,644,968	$ 11,574,019	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		680,077	13
14	Buildings, at Historical Cost		4,894,437	14
15	Leasehold Improvements, at Historical Cost	2,292,733	2,392,122	15
16	Equipment, at Historical Cost	991,163	1,578,447	16
17	Accumulated Depreciation (book methods)	(2,766,939)	(5,094,344)	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	4,392,728	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,662,494	$ 8,843,467	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,307,462	$ 20,417,486	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 6,121,551	$ 6,121,551	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	45,421	45,421	28
29	Short-Term Notes Payable	26,417	26,417	29
30	Accrued Salaries Payable	321,490	321,490	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,523	8,523	31
32	Accrued Real Estate Taxes(Sch.IX-B)	242,884	242,884	32
33	Accrued Interest Payable	123,254	168,733	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	162,707	324,549	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,052,247	$ 7,259,568	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	222,574	222,574	39
40	Mortgage Payable		10,778,374	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	$ 11,000,948	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,274,821	$ 18,260,516	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,032,641	$ 2,156,970	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,307,462	$ 20,417,486	48

***(See instructions.)**

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,530,464	1
2	Restatements (describe):		2
3	Rounding	3	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,530,467	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	502,174	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)**	$ 502,174	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)**	$ 2,032,641	24 *

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

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,559,913	1
2	Discounts and Allowances for all Levels	(1,521,806)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,038,107	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,590,968	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,590,968	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	89,181	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,934	19
20	Radiology and X-Ray	2,920	20
21	Other Medical Services	15,599	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 117,634	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	57,501	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 57,501	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	25	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 25	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,804,235	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,781,854	31
32	Health Care	3,894,756	32
33	General Administration	1,989,936	33
	B. Capital Expense		
34	Ownership	1,321,752	34
	C. Ancillary Expense		
35	Special Cost Centers	831,970	35
36	Provider Participation Fee	481,793	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,302,061	40
41	**Income before Income Taxes (line 30 minus line 40)****	502,174	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 502,174	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,904,734	44
45	Private Pay - Net Inpatient Revenue	89,712	45
46	Medicare - Net Inpatient Revenue	(82,595)	46
47	Other-(specify)		47
48	Other-(specify)	126,256	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,038,107	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.**

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	1,515	1,728	$ 88,520	$ 51.23	1
2	Assistant Director of Nursing	1,950	2,722	103,941	38.19	2
3	Registered Nurses	17,930	20,907	690,532	33.03	3
4	Licensed Practical Nurses	36,769	40,650	1,023,122	25.17	4
5	CNAs & Orderlies	86,085	95,001	1,142,555	12.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,398	9,063	138,819	15.32	8
9	Activity Director	1,796	2,108	28,984	13.75	9
10	Activity Assistants	8,753	9,632	97,196	10.09	10
11	Social Service Workers	13,952	14,985	274,949	18.35	11
12	Dietician					12
13	Food Service Supervisor	1,958	2,230	41,407	18.57	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,380	7,417	90,183	12.16	15
16	Dishwashers	13,309	14,973	151,420	10.11	16
17	Maintenance Workers	14,469	16,166	207,513	12.84	17
18	Housekeepers	21,983	24,468	242,386	9.91	18
19	Laundry	9,670	10,558	112,823	10.69	19
20	Administrator	1,410	1,837	88,754	48.31	20
21	Assistant Administrator	2,086	2,152	46,565	21.64	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,473	7,381	100,620	13.63	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	1,620	1,785	21,427	12.00	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	7,421	7,421	291,811	39.32	33
34	TOTAL (lines 1 - 33)	263,927	293,184	$ 4,983,527 *	$ 17.00	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	258	$ 14,247	01-03	35
36	Medical Director	Monthly	3,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,218	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	37,460	12-03	45
46	Other(specify)				46
47	Psychiatrist Consultant	Monthly	25,800	10-03	47
48					48
49	TOTAL (lines 35 - 48)	258	$ 91,225		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

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Shloimy Langsner	AIT	0	$ 46,565
Kayla Moore	Administrator	0	17,318
Erina Wittrock	Administrator	0	71,436
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 135,319

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
Pro Payroll Solutions	Payroll Processing	$ 25,165
eHealth Data Solutions	MDS Software	3,975
On Shift	Shift Scheduling Software	1,178
AIS Assessment & Intelligence	MDS Consultant	1,319
Ability Network	Medicare Billing	563
National Datacare Corporation	Resident Fund Processing	3,265
Extended Care Consulting	Home Office Expense	144,000
FRR / Marcum	Accounting	28,699
Personnel Planners	Unemployment Consultant	2,375
Admiral Environmental Services	Environmental Services	307
The William Everett Group	IT Consultant	160
See Supplemental Schedule		143,510
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 354,514

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 102,948
Unemployment Compensation Insurance	60,656
FICA Taxes	377,055
Employee Health Insurance	221,700
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	1,326
Pension	40,457
Other Employee Benefits	9,008
Holiday Expense	5,973
TOTAL (agree to Schedule V, line 22, col.8)	$ 819,123

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	2,066
Health Care Worker Background Check	
(Indicate # of checks performed 131)	2,971
Patient Background Checks	
Dues and Subscriptions	32,415
Licenses and Fees	2,134
Allocated from Extended Care Consulting	1,341
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 42,917

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,795
Allocated from Extended Care Consulting	461
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,256

**See instructions.

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 $26,388**

(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. $ **24,129** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **481,793**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.