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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0040444

Facility Name: Sheridan Shores Care

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

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 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: Steven N. 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 01/01/17 to 12/31/17 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)
** Subject to the attached Accountants' Consulting Report*
(Date)
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 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 Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		782	7,129	7,911	8
9	SNF/PED					9
10	ICF	57,188			57,188	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	57,188	782	7,129	65,099	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.38%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 5/1/1993

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 5/1/1993 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 2,300

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: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	346,521	73,510	21,350	441,381		441,381	240	441,621			1
2	Food Purchase		430,442		430,442		430,442	649	431,091			2
3	Housekeeping	295,140	55,379		350,519		350,519	1,451	351,970			3
4	Laundry	113,685	23,087		136,772		136,772		136,772			4
5	Heat and Other Utilities			193,779	193,779		193,779	1,797	195,576			5
6	Maintenance	251,774	81	209,919	461,774		461,774	10,517	472,291			6
7	Other (specify):*							985	985			7
8	**TOTAL General Services**	1,007,120	582,499	425,048	2,014,667		2,014,667	15,639	2,030,306			8
	B. Health Care and Programs											
9	Medical Director			4,200	4,200		4,200		4,200			9
10	Nursing and Medical Records	3,095,155	217,008	38,910	3,351,073		3,351,073	(3,099)	3,347,974			10
10a	Therapy	159,556			159,556		159,556		159,556			10a
11	Activities	147,981	27,650		175,631		175,631		175,631			11
12	Social Services	337,538	4,416	33,250	375,204		375,204		375,204			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,740,230	249,074	76,360	4,065,664		4,065,664	(3,099)	4,062,565			16
	C. General Administration											
17	Administrative	88,524			88,524		88,524	25,000	113,524			17
18	Directors Fees											18
19	Professional Services			287,212	287,212	(13,386)	273,826	(139,982)	133,844			19
20	Dues, Fees, Subscriptions & Promotions			49,936	49,936		49,936	(18,885)	31,051			20
21	Clerical & General Office Expenses	113,778	38,770	378,516	531,064		531,064	(121,432)	409,632			21
22	Employee Benefits & Payroll Taxes			873,378	873,378		873,378	(7,555)	865,823			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,872	4,872		4,872	46	4,918			24
25	Other Admin. Staff Transportation			9,222	9,222		9,222	1,201	10,423			25
26	Insurance-Prop.Liab.Malpractice			209,191	209,191		209,191	2,167	211,358			26
27	Other (specify):*							35,752	35,752			27
28	**TOTAL General Administration**	202,302	38,770	1,812,327	2,053,399	(13,386)	2,040,013	(223,688)	1,816,325			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,949,652	870,343	2,313,735	8,133,730	(13,386)	8,120,344	(211,148)	7,909,196			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 Care #0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			91,178	91,178		91,178	182,991	274,169			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			505	505		505	469,121	469,626			32
33	Real Estate Taxes			303,910	303,910	13,386	317,296	5,413	322,709			33
34	Rent-Facility & Grounds			936,000	936,000		936,000	(936,000)				34
35	Rent-Equipment & Vehicles			17,559	17,559		17,559	1,327	18,886			35
36	Other (specify):*			414,554	414,554		414,554	(414,554)				36
37	**TOTAL Ownership**			1,763,706	1,763,706	13,386	1,777,092	(691,702)	1,085,390			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		22,075	436,192	458,267		458,267	(4,691)	453,576			39
40	Barber and Beauty Shops			216	216		216		216			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			481,680	481,680		481,680		481,680			42
43	Other (specify):*	404,792		60,000	464,792		464,792	(464,792)				43
44	**TOTAL Special Cost Centers**	404,792	22,075	978,088	1,404,955		1,404,955	(469,483)	935,472			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,354,444	892,418	5,055,529	11,302,391		11,302,391	(1,372,333)	9,930,058			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 Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	(3,353)	30		9
10	Interest and Other Investment Income	(54,700)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(52)	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	(1,310)	21		18
19	Entertainment				19
20	Contributions	(5,000)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(254,149)	21		24
25	Fund Raising, Advertising and Promotional	(2,760)	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	(969,976)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,291,300)		$	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)	(81,033)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (81,033)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,372,333)		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 Care

ID# **0040444**

Report Period Beginning: **01/01/17**

Ending: **12/31/17**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Jury Duty Income	$ (34)	10	1
2	Patient Clothing	(955)	10	2
3	Theft Loss	(55)	21	3
4	Collection Expense	(2,448)	21	4
5	Amortization	(414,554)	36	5
6	Building Company - Management Fees	(9,400)	19	6
7	Building Company - Bank Charges	(364)	21	7
8	Building Company - Filing Fees	(250)	21	8
9	Building Company - Amortization	(51,754)	36	9
10	PAC Dues	(12,201)	20	10
11	Non-Allowable Legal	(813)	19	11
12	Non-Allowable Salaries	(404,792)	43	12
13	Non-Allowable Fees	(60,000)	43	13
14	Loan Fees	(7,305)	21	14
15	Capitalized R&M	(5,051)	6	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**	(969,976)		49

Sheridan Shores Care

ID# 0040444

Report Period Beginning: 01/01/17

Ending: 12/31/17

	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 Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			240									240	1
2	Food Purchase	(52)		701									649	2
3	Housekeeping			1,451									1,451	3
4	Laundry													4
5	Heat and Other Utilities			1,797									1,797	5
6	Maintenance	(5,051)		4,949	10,619								10,517	6
7	Other (specify):*				985								985	7
8	TOTAL General Services	(5,103)		9,138	11,604								15,639	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(989)				(2,110)							(3,099)	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	(989)				(2,110)							(3,099)	16
	C. General Administration													
17	Administrative			3,704	21,296								25,000	17
18	Directors Fees													18
19	Professional Services	(10,213)	9,400	(139,239)		70							(139,982)	19
20	Fees, Subscriptions & Promotions	(19,961)		1,076									(18,885)	20
21	Clerical & General Office Expenses	(265,881)	614	10,642	133,193								(121,432)	21
22	Employee Benefits & Payroll Taxes				(7,555)								(7,555)	22
23	Inservice Training & Education													23
24	Travel and Seminar			46									46	24
25	Other Admin. Staff Transportation			1,201									1,201	25
26	Insurance-Prop.Liab.Malpractice			2,167									2,167	26
27	Other (specify):*				35,752								35,752	27
28	TOTAL General Administration	(296,055)	10,014	(120,403)	182,686	70							(223,688)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(302,147)	10,014	(111,265)	194,290	(2,040)							(211,148)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sheridan Shores Care # 0040444 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(3,353)	183,264	3,080									182,991	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(54,700)	504,530	19,291									469,121	32
33	Real Estate Taxes			5,413									5,413	33
34	Rent-Facility & Grounds		(936,000)										(936,000)	34
35	Rent-Equipment & Vehicles			1,327									1,327	35
36	Other (specify):*	(466,308)	51,754										(414,554)	36
37	**TOTAL Ownership**	(524,361)	(196,452)	29,111									(691,702)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(4,691)							(4,691)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(464,792)											(464,792)	43
44	**TOTAL Special Cost Centers**	(464,792)				(4,691)							(469,483)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,291,300)	(186,438)	(82,154)	194,290	(6,731)							(1,372,333)	45

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	19	Management Fees		Sheridan Shores Property, LLC	100.00%	9,400	9,400	2
3	V	21	Bank Service Charge		Sheridan Shores Property, LLC	100.00%	364	364	3
4	V	21	Filing Fee		Sheridan Shores Property, LLC	100.00%	250	250	4
5	V	30	Depreciation		Sheridan Shores Property, LLC	100.00%	183,264	183,264	5
6	V	36	Amortization		Sheridan Shores Property, LLC	100.00%	51,754	51,754	6
7	V	32	Interest		Sheridan Shores Property, LLC	100.00%	504,530	504,530	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 936,000			$ 749,562	$ * (186,438)	14

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

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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%	$ 240	$ 240	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	701	701	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	1,451	1,451	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,797	1,797	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	4,949	4,949	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	3,704	3,704	20
21	V	19	Professional Fees	144,000	Extended Care Consulting, LLC	100.00%	4,761	(139,239)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,076	1,076	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	10,642	10,642	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	46	46	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,201	1,201	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	2,167	2,167	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	3,080	3,080	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	19,291	19,291	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	5,413	5,413	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,327	1,327	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 144,000			$ 61,846	$ * (82,154)	39

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

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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%	10,619	$ 10,619	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%	985	985	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%	21,296	21,296	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	133,193	133,193	22
23	V	21	Office and Clerical (Direct)	25,182	Extended Care Consulting, LLC	100.00%	25,182		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	29,851	29,851	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	5,901	5,901	25
26	V	22	Employee Benefits	7,555	Extended Care Consulting, LLC	100.00%		(7,555)	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			$ 32,737			$ 227,027	$ * 194,290	39

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

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$	MAC Rx, LLC	100.00%	$	$	15
16	V	10	Nursing and Medical Records	25,545	MAC Rx, LLC	100.00%	23,435	(2,110)	16
17	V	10A	Therapy		MAC Rx, LLC	100.00%			17
18	V	19	Professional Services	(851)	MAC Rx, LLC	100.00%	(781)	70	18
19	V	21	Clerical & General Office Expenses		MAC Rx, LLC	100.00%			19
20	V	22	Employee Benefits		MAC Rx, LLC	100.00%			20
21	V	39	Ancillary	56,796	MAC Rx, LLC	100.00%	52,105	(4,691)	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			$ 81,490			$ 74,759	$ * (6,731)	39

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

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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%	$ 216,377	$ 216,377	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	216,377	CCS Employee Benefits Group	100.00%		(216,377)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 216,377			$ 216,377	$ *	39

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

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	CHICAGO	BUILDING COMPANY	1
2	ERIC ROTHNER GRANTOR TRUST	29.79%	BRIAR PLACE LTD.	INDIAN HEAD PARK	EXTENDED CARE CONSULTING	EVANSTON	MGMT/BOOKKEEPING	2
3	NATHAN & SHIRLEY ROTHNER FAMILY TRUST	54.25%	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 COMPANY	4
5			GRASMERE PLACE, LLC	CHICAGO	VENT LEASE LLC	EVANSTON	NURSING EQUIPMENT	5
6			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	6
7			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	MAC RX	DES PLAINES	PHARMACY	7
8			MAJOR HOSPITAL DYER	DYER, IN	RELIABLE MEDICAL SUPPLY	DES PLAINES	MEDICAL SUPPLIES	8
9			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				9
10			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				10
11			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				11
12			MAJOR HOSPITAL SEBOS	HOBART, IN				12
13			MCKINLEY HEALTH CARE CENTER	CANTON, OH				13
14			LITTLE VILLAGE NURSING & REHABILITATION CENTER, L.L.C.	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			SPRING MILL HEALTH CAMPUS	MERRIVILLE, IN				21
22			ST. JAMES WELLNESS REHAB VILLAS	CRETE				22
23			THE ESTATES OF HYDE PARK	CHICAGO				23
24			THE PARC AT JOLIET	JOLIET				24
25			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				25
26			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				26
27			WHEATON CARE CENTER	WHEATON				27
28								28
29								29
30								30

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

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

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	3.66	6.65%	Alloc Sal/Fee	$ 13,306	17-7	1
2	Adam Vales	Relative	Clerical	0%	See Attached	0.96	2.40%	Alloc Salary	1,663	21-7	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	$ 14,969		13

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

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

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1,476,506	37	$ 5,451	$	65,099	$ 240	1
2	02	Food	Patient Days	1,476,506	37	15,903		65,099	701	2
3	03	Housekeeping	Patient Days	1,476,506	37	32,901		65,099	1,451	3
4	05	Utilities	Patient Days	1,476,506	37	40,755		65,099	1,797	4
5	06	Maintenance	Patient Days	1,476,506	37	112,249		65,099	4,949	5
6	17	Administrative	Patient Days	1,476,506	37	84,000		65,099	3,704	6
7	19	Professional Fees	Patient Days	1,476,506	37	107,994		65,099	4,761	7
8	20	Dues and Subscriptions	Patient Days	1,476,506	37	24,409		65,099	1,076	8
9	21	Office and Clerical	Patient Days	1,476,506	37	241,371		65,099	10,642	9
10	24	Seminar and Travel	Patient Days	1,476,506	37	1,048		65,099	46	10
11	25	Other Staff Admin. Trans.	Patient Days	1,476,506	37	27,239		65,099	1,201	11
12	26	Insurance	Patient Days	1,476,506	37	49,139		65,099	2,167	12
13	30	Depreciation	Patient Days	1,476,506	37	69,861		65,099	3,080	13
14	32	Interest	Patient Days	1,476,506	37	437,528		65,099	19,291	14
15	33	Real Estate Taxes	Patient Days	1,476,506	37	122,769		65,099	5,413	15
16	35	Rent - Equipment & Auto	Patient Days	1,476,506	37	30,092		65,099	1,327	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,402,709	$		$ 61,846	25

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1,476,506	37	240,841	240,841	65,099	10,619	1
2	06	Maintenance (Direct)	Direct		21	358,056	358,056			2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,476,506	37	22,330		65,099	985	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		21	51,193				4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,476,506	37	483,002	483,002	65,099	21,296	7
8	21	Office and Clerical (Pooled)	Patient Days	1,476,506	37	3,020,951	3,020,951	65,099	133,193	8
9	21	Office and Clerical (Direct)	Direct		28	498,631	498,631		25,182	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,476,506	37	677,040		65,099	29,851	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		28	74,203			5,901	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					$ 5,426,248	$ 4,601,481		$ 227,027	25

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	06	Maintenance	Direct Allocation			$	$		$	1
2	10	Nursing And Medical Records	Direct Allocation						23,435	2
3	10A	Therapy	Direct Allocation							3
4	19	Professional Services	Direct Allocation						(781)	4
5	21	Clerical & General Office Expense	Direct Allocation							5
6	22	Employee Benefits	Direct Allocation							6
7	39	Ancillary	Direct Allocation						52,105	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					$	$		$ 74,759	25

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			$	$		$ 216,377	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 216,377	25

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Bank Leumi		X	Mortgage			$	$ 9,963,204			$ 504,530	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Shareholder Loan	X		Line of Credit				222,574				6
7												7
8												8
9	TOTAL Facility Related						$	$ 10,185,778			$ 504,530	9
	B. Non-Facility Related*											
10	Interest Income										(54,700)	10
11	Misc Interest Expense										505	11
12	Allocated from Extended Care Consulting										19,291	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (34,904)	14
15	TOTALS (line 9+line14)						$	$ 10,185,778			$ 469,626	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 Care # 0040444 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 268,007	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.)		$ 284,397	2
3. Under or (over) accrual (line 2 minus line 1).		$ 16,390	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 292,933	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.)		$ 13,386	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** $ 39,246 **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.		$ 322,709	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	223,723	8
	2013	226,750	9
	2014	231,318	10
	2015	255,245	11
	2016	278,984	12

2017 Accrual = 2016 Tax + 5% (278,984 x 1.05 = 292,933)

Allocated from Extended Care Consulting = $5,413

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sheridan Shores Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040444

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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	$ 139,491.84	$ 139,491.84
2.	14-05-402-028-0000	Long Term Care Property	$ 139,491.84	$ 139,491.84
3.	See Attached	Allocated from Care Centers Building	$ 181,041.00	$ 5,413.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 460,024.68	$ 284,396.68

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 2016 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 2016 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2016.

Please complete the Real Estate Tax Statement below and include it in the 2017 cost report along with a copy of your 2016 real estate tax bill.

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 Bureau of Health Finance at (217) 782-1630.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sheridan Shores Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040444

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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 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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Care Center Building			24,517	2
3	TOTALS			$ 715,440	3

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 183,264	39	$ 114,007	$ (69,257)	$ 1,487,139	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			146,422	11
12	Various			1996	67,704		20			67,281	12
13	Various			1997	53,902		20	1,208	1,208	53,895	13
14	Various			1998	172,679		20	8,634	8,634	169,199	14
15	Various			1999	62,682		20	3,134	3,134	58,172	15
16	Various			2000	149,525		20	7,450	7,450	131,050	16
17	Various			2001	56,462		20	2,823	2,823	47,368	17
18	Various			2002	66,781		20	243	243	65,765	18
19	Various			2003	88,237		20			88,237	19
20	Various			2004	93,862		20	440	440	91,368	20
21	Various			2005	446,038		20	20,402	20,402	291,205	21
22	Various			2006	105,189		20			105,189	22
23	Various			2007	43,478		20	1,583	1,583	43,047	23
24	Various			2008	63,072		20	5,980	5,980	55,708	24
25	Various			2009	299,085		20	16,059	16,059	145,194	25
26	Various			2010	115,579		20	6,777	6,777	99,603	26
27	Various			2011	96,687		20	8,208	8,208	57,672	27
28	Various			2012	78,539		20	6,538	6,538	38,163	28
29	Various			2013	50,710		20	5,071	5,071	23,562	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	135,766	67
68	Related Party Allocations (Pages 12H & 12I)		121,794	1,849		1,849		80,793	68
69	Financial Statement Depreciation			91,178			(91,178)		69
70	TOTAL (lines 4 thru 69)		$ 7,477,691	$ 276,291		$ 238,036	$ (38,255)	$ 3,582,203	70

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

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 7,477,691	$ 276,291		$ 238,036	$ (38,255)	$ 3,582,203	1
2	Repair Leaking Drain Line	2014	2,868		20	287	287	1,123	2
3	Removed & Installed Rebuilt Sewage Pump	2014	3,695		20	370	370	1,386	3
4	South & North Stairwell Fire Protection	2014	22,452		20	2,245	2,245	8,232	4
5	Emergency Generator	2014	67,670		20	3,384	3,384	11,842	5
6	Water Heater	2014	16,992		20	850	850	2,690	6
7	Pt Room & Hallway - Metal Frames, Outlets, Lights, Drywall	2014	6,800		20	340	340	1,048	7
8	Indoor & Outdoor Bells, Basement Tamper	2014	2,867		20	143	143	573	8
9	Replace Sprinkler System Heads	2014	5,011		20	251	251	981	9
10	Elevator Transmitter & Receiver Units	2014	3,450		20	173	173	647	10
11	Boiler Repair - New Tubes & Gaskets	2015	4,098		20	205	205	529	11
12	New Barrel For Parking Door	2015	4,527		20	226	226	509	12
13	Leaking Valve, Coupling Guards In Basement Maint Shop	2016	5,250		20	263	263	481	13
14	Rebuild Boiler #2	2016	5,760		20	288	288	528	14
15	2 200-Gallon Storage Tanks	2016	23,900		20	1,195	1,195	2,290	15
16	Repair Of Pipes & Water Leaks In Basement/Lunch Room	2016	13,529		20	676	676	1,296	16
17	New Exhaust Fan	2016	2,700		20	135	135	203	17
18	Generator Control Panel	2016	4,090		20	205	205	273	18
19	21 Smoke Dampers & 9 Fire Dampers	2016	8,927		20	446	446	670	19
20	2 Ejector Pumps	2016	14,985		20	749	749	937	20
21	Coupling Guard Installation - Basement Maintenance Shop	2016	4,141		20	207	207	380	21
22	Replaced Damaged Pieces In Water Feed Line In Water Tower	2016	3,464		20	173	173	274	22
23	Iron Pipe And Fitting Servicing Main Sanitary Line	2016	3,024		20	151	151	151	23
24	2 Shunt Trip Enclosures	2017	14,975		20	749	749	749	24
25	New Load Center & Circuit Breakers In Boiler Room	2017	5,350		20	111	111	111	25
26	Generator-Replace Water Level Sensor & Motor Solenoid	2017	3,586		20	30	30	30	26
27	Fire Alarm System - Replace Actuator On Dry Valve	2017	2,530		20	126	126	126	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,734,332	$ 276,291		$ 252,013	$ (24,278)	$ 3,620,264	34

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

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 7,734,332	$ 276,291		$ 252,013	$ (24,278)	$ 3,620,264	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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)		$ 7,734,332	$ 276,291		$ 252,013	$ (24,278)	$ 3,620,264	34

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

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 7,734,332	$ 276,291		$ 252,013	$ (24,278)	$ 3,620,264	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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)		$ 7,734,332	$ 276,291		$ 252,013	$ (24,278)	$ 3,620,264	34

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

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 7,734,332	$ 276,291		$ 252,013	$ (24,278)	$ 3,620,264	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
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)		$ 7,734,332	$ 276,291		$ 252,013	$ (24,278)	$ 3,620,264	34

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

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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									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	126,250	9
10	Resurface Parking Deck	2014	47,570		20	2,379	2,379	9,516	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	$ 135,766	34

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

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$	$ 135,766	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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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	$	$ 135,766	34

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

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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-Care Center Bldg	2002	33,785	866	35	866		13,247	3
4	Allocated from Extended Care Consulting- Dyer Bldg	2007	10,582	234	35	234		2,461	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting, LLC	2007	203	10	20	10		112	9
10	Allocated from Extended Care Consulting, LLC	2009	121	6	20	6		55	10
11	Allocated from Extended Care Consulting, LLC	2010	1,189	59	20	59		476	11
12	Allocated from Extended Care Consulting, LLC	2011	428	21	20	21		150	12
13	Allocated from Extended Care Consulting, LLC	2012	141	7	20	7		42	13
14	Allocated from Extended Care Consulting, LLC	2014	1,955	98	20	98		391	14
15	Allocated from Extended Care Consulting, LLC	2016	2,345	117	20	117		234	15
16									16
17	Allocated from Extended Care Consulting-Care Center Bldg	2002	27,909		20			27,909	17
18	Allocated from Extended Care Consulting-Care Center Bldg	2003	32,890		20			32,890	18
19	Allocated from Extended Care Consulting-Care Center Bldg	2005	1,634		20			1,634	19
20	Allocated from Extended Care Consulting-Care Center Bldg	2009	295	15	20	15		133	20
21	Allocated from Extended Care Consulting-Care Center Bldg	2014	2,830	142	20	142		566	21
22	Allocated from Extended Care Consulting-Care Center Bldg	2015	465	23	20	23		150	22
23	Allocated from Extended Care Consulting-Care Center Bldg	2016	1,837	92	20	92		184	23
24	Allocated from Extended Care Consulting-Care Center Bldg	2017	3,185	159	20	159		159	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)		$ 121,794	$ 1,849		$ 1,849	$	$ 80,793	34

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

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 121,794	$ 1,849		$ 1,849	$	$ 80,793	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 121,794	$ 1,849		$ 1,849	$	$ 80,793	34

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

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 374,113	$ 1,005	$ 21,678	$ 20,673	10	$ 344,167	71
72	Current Year Purchases	2,521		252	252	10	252	72
73	Fully Depreciated Assets	1,131,670				10	1,131,670	73
74								74
75	TOTALS	$ 1,508,304	$ 1,005	$ 21,930	$ 20,925		$ 1,476,089	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 Extended Care Consulting		$ 7,957	$ 225	$ 225	$	5	$ 7,732	76
77										77
78										78
79										79
80	TOTALS			$ 7,957	$ 225	$ 225	$		$ 7,732	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)	$ 9,966,033	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 277,521	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 274,168	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (3,353)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,104,086	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 7,896 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	$ 916	$ 10,990	17
18					18
19					19
20					20
21	TOTAL		$ 916	$ 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 Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$		$ 200,918	$		$ 200,918	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			33,390			33,390	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			201,884			201,884	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				6,299		6,299	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):						15,776		15,776	13
14	TOTAL			$		$ 436,192	$ 22,075		$ 458,267	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 Care **#** 0040444 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/17 **(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	$ 25,957	$ 110,883	1
2	Cash-Patient Deposits	57,737	57,737	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,085,094	1,085,094	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	71,003	71,003	6
7	Other Prepaid Expenses	8,657	8,657	7
8	Accounts Receivable (owners or related parties)		1,000	8
9	Other(specify): See Attached Schedule	3,233,021	2,945,407	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,481,469	$ 4,279,781	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	2,392,444	2,491,833	15
16	Equipment, at Historical Cost	987,024	1,574,308	16
17	Accumulated Depreciation (book methods)	(2,949,063)	(5,643,198)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	2,903,739	9,478,953	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,334,144	$ 13,476,410	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,815,613	$ 17,756,191	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 5,432,502	$ 5,432,502	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	52,831	52,831	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	382,726	382,726	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,519	16,519	31
32	Accrued Real Estate Taxes(Sch.IX-B)	292,933	292,933	32
33	Accrued Interest Payable		42,039	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,177,511	$ 6,219,550	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	222,574	222,574	39
40	Mortgage Payable		9,963,204	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	$ 10,185,778	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,400,085	$ 16,405,328	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,415,528	$ 1,350,863	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,815,613	$ 17,756,191	48

***(See instructions.)**

Facility Name & ID Number Sheridan Shores Care **#** 0040444 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,535,682	1
2	Restatements (describe):		2
3	**Rounding**	9	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,535,691	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(120,163)	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)**	$ (120,163)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,415,528	24 *

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

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 10,707,044	1
2	Discounts and Allowances for all Levels	(1,379,049)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,327,995	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,499,392	6
7	Oxygen	47	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,499,439	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	207,551	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,380	19
20	Radiology and X-Ray	2,420	20
21	Other Medical Services	44,463	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 260,814	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	54,700	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 54,700	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	39,280	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 39,280	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,182,228	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,014,667	31
32	Health Care	4,065,664	32
33	General Administration	2,053,399	33
	B. Capital Expense		
34	Ownership	1,763,706	34
	C. Ancillary Expense		
35	Special Cost Centers	923,275	35
36	Provider Participation Fee	481,680	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,302,391	40
41	**Income before Income Taxes (line 30 minus line 40)****	(120,163)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (120,163)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 9,068,717	44
45	Private Pay - Net Inpatient Revenue	133,130	45
46	Medicare - Net Inpatient Revenue	77,605	46
47	Other-(specify) Insurance	9,569	47
48	Other-(specify) Hospice	38,974	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,327,995	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 Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	3,593	3,718	$ 196,244	$ 52.78	1
2	Assistant Director of Nursing	2,024	3,263	119,532	36.63	2
3	Registered Nurses	17,684	20,706	638,330	30.83	3
4	Licensed Practical Nurses	32,591	36,760	991,717	26.98	4
5	CNAs & Orderlies	68,549	79,498	1,126,884	14.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,565	8,377	159,556	19.05	8
9	Activity Director	1,667	1,882	27,225	14.47	9
10	Activity Assistants	9,425	10,280	120,756	11.75	10
11	Social Service Workers	16,758	18,225	337,538	18.52	11
12	Dietician					12
13	Food Service Supervisor	2,366	2,558	42,387	16.57	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,041	24,658	304,134	12.33	15
16	Dishwashers					16
17	Maintenance Workers	16,204	17,757	251,774	14.18	17
18	Housekeepers	22,924	25,327	295,140	11.65	18
19	Laundry	8,129	8,725	113,685	13.03	19
20	Administrator	2,061	2,204	88,524	40.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,426	7,115	113,778	15.99	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	1,641	1,872	22,448	11.99	31
32	Other Health Care(specify)					32
33	Other(specify)	8,278	8,756	404,792	46.23	33
34	TOTAL (lines 1 - 33)	248,926	281,681	$ 5,354,444 *	$ 19.01	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	374	$ 21,350	01-03	35
36	Medical Director	Monthly	4,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	14,010	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	33,250	12-03	45
46	Other(specify)				46
47	Psychiatrist	Monthly	24,900	10-03	47
48					48
49	TOTAL (lines 35 - 48)	374	$ 97,710		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 Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Erina Wittrock	Administrator	0	$ 88,524
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 88,524

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
Marcum LLP	Accounting	$ 35,129
Pro Payroll Solutions	Payroll Services	27,244
Matrixcare	Billing Software	26,547
MacRX	Professional Fees	(851)
National Datacare Corporation	Data Processing	2,970
On Shift	Scheduling Software	5,210
Extended Care Consulting	Home Office Expense	144,000
See Attached	Legal	23,194
Personnel Planners	Unemployment Consultant	1,246
Blymas Inc.	Tax Credit Consulting	3,649
Legat Architect	Architect	3,606
See Supplemental Schedule		15,268
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 287,212

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 101,272
Unemployment Compensation Insurance	27,250
FICA Taxes	403,762
Employee Health Insurance	274,565
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	1,800
Pension Expense	39,396
Other Employee Welfare	9,954
Holiday Expense	7,824
TOTAL (agree to Schedule V, line 22, col.8)	$ 865,823

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	5,865
Health Care Worker Background Check	
(Indicate # of checks performed 55)	
Patient Background Checks	3,571
Dues & Subscriptions	16,896
Licenses & Fees	1,653
Allocated from Extended Care Consulting	1,076
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 31,051

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,872
Allocated from Extended Care Consulting	46
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,918

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Sheridan Shores Care # 0040444 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 $24,403**

(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. $ **38,630** 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.

(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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **481,680**
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. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% line 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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