

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr

0040444 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	58,790	677	6,380	65,847	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	58,790	677	6,380	65,847	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.45%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 05/01/1993

J. Was the facility purchased or leased after January 1, 1978?

YES Date 05/01/1993 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 63 and days of care provided 6,380

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Sheridan Shores Cr & Reh Ctr

0040444

Report Period Beginning:

01/01/13

Ending:

12/31/13

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	259,076	41,281	16,527	316,884		316,884	(819)	316,065		1
2	Food Purchase		340,743		340,743		340,743	723	341,466		2
3	Housekeeping	236,848	69,920		306,768		306,768	759	307,527		3
4	Laundry	95,537	27,826		123,363		123,363		123,363		4
5	Heat and Other Utilities			191,789	191,789		191,789	1,003	192,792		5
6	Maintenance	203,300	47	230,654	434,001		434,001	19,031	453,032		6
7	Other (specify):*							2,813	2,813		7
8	TOTAL General Services	794,761	479,817	438,970	1,713,548		1,713,548	23,511	1,737,059		8
	B. Health Care and Programs										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	2,657,371	89,168	35,020	2,781,559		2,781,559	(1,925)	2,779,634		10
10a	Therapy	137,331			137,331		137,331		137,331		10a
11	Activities	133,334	24,699		158,033		158,033		158,033		11
12	Social Services	364,366	8,015	21,024	393,405		393,405		393,405		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,292,402	121,882	59,644	3,473,928		3,473,928	(1,925)	3,472,003		16
	C. General Administration										
17	Administrative	359,639		60,000	419,639		419,639	32,733	452,372		17
18	Directors Fees										18
19	Professional Services			252,782	252,782	(5,777)	247,005	(137,624)	109,381		19
20	Dues, Fees, Subscriptions & Promotions			39,165	39,165		39,165	(16,197)	22,969		20
21	Clerical & General Office Expenses	88,544	53,623	266,555	408,722		408,722	25,348	434,070		21
22	Employee Benefits & Payroll Taxes			747,134	747,134		747,134	(11,082)	736,052		22
23	Inservice Training & Education										23
24	Travel and Seminar			12,745	12,745		12,745	(44)	12,701		24
25	Other Admin. Staff Transportation			13,598	13,598		13,598	956	14,554		25
26	Insurance-Prop.Liab.Malpractice			180,994	180,994		180,994	1,598	182,592		26
27	Other (specify):*							43,166	43,166		27
28	TOTAL General Administration	448,183	53,623	1,572,973	2,074,779	(5,777)	2,069,002	(61,145)	2,007,857		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,535,346	655,322	2,071,587	7,262,255	(5,777)	7,256,478	(39,559)	7,216,918		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr

#0040444

Report Period Beginning:

01/01/13

Ending:

12/31/13

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			160,598	160,598		160,598	152,310	312,908			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,904	1,904		1,904	640,226	642,130			32
33	Real Estate Taxes			278,271	278,271	5,777	284,048	3,929	287,977			33
34	Rent-Facility & Grounds			900,000	900,000		900,000	(900,000)				34
35	Rent-Equipment & Vehicles			20,682	20,682		20,682	1,441	22,123			35
36	Other (specify):*											36
37	TOTAL Ownership			1,361,455	1,361,455	5,777	1,367,232	(102,094)	1,265,139			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		418,327	649,718	1,068,045		1,068,045	(532)	1,067,513			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			464,184	464,184		464,184		464,184			42
43	Other (specify):*			2,050	2,050		2,050	(2,050)				43
44	TOTAL Special Cost Centers		418,327	1,115,952	1,534,279		1,534,279	(2,582)	1,531,697			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,535,346	1,073,649	4,548,994	10,157,989		10,157,989	(144,235)	10,013,754			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	19,996	30		9
10	Interest and Other Investment Income	(5,945)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(35)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(6,250)	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	(165,000)	21		24
25	Fund Raising, Advertising and Promotional	(4,360)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(23)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(78,621)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (240,237)		\$	30

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	2	
		Amount	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)	96,003		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 96,003		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (144,235)		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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Sheridan Shores Cr & Reh Ctr

ID# 0040444

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Out of Period Auto Expense	\$ (569)	25	1
2	Refund of Insurance Overpayment	(455)	26	2
3	Rebate	(5)	21	3
4	Jury Duty Income	(17)	10	4
5	Patient Clothing	(1,908)	10	5
6	Cook County Sales Tax	(914)	21	6
7	Theft Loss	(334)	21	7
8	Collection Expense	(3,205)	21	8
9	COPE Dues	(9,157)	20	9
10	Bldg Co. - Admin Expense	(310)	21	10
11	Bldg Co. - Bank Charges	(255)	21	11
12	Bldg Co. - Filing Fees	(498)	21	12
13	Bldg Co. - Amortization	(50,228)	31	13
14	Non Allowable Seminar	(619)	24	14
15	Annual Reports	(913)	20	15
16	Marketing	(2,050)	43	16
17	Out of Period Professional Fees	(823)	21	17
18	Non Allowable Legal	(6,362)	19	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	(78,621)	49

Sheridan Shores Cr & Reh Ctr

ID# 0040444

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32

82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr# 0040444

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			430		(1,249)							(819)	1
2	Food Purchase	(35)		758									723	2
3	Housekeeping			759									759	3
4	Laundry													4
5	Heat and Other Utilities			1,003									1,003	5
6	Maintenance			6,548	12,483								19,031	6
7	Other (specify):*				2,813								2,813	7
8	TOTAL General Services	(35)		9,498	15,296	(1,249)							23,511	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,925)											(1,925)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(1,925)											(1,925)	16
	C. General Administration													
17	Administrative			5,020	27,713								32,733	17
18	Directors Fees													18
19	Professional Services	(6,362)		(131,262)									(137,624)	19
20	Fees, Subscriptions & Promotions	(20,680)		4,483									(16,197)	20
21	Clerical & General Office Expenses	(171,367)	1,063	21,189	174,463								25,348	21
22	Employee Benefits & Payroll Taxes				(11,082)								(11,082)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(619)		575									(44)	24
25	Other Admin. Staff Transportation	(569)		1,525									956	25
26	Insurance-Prop.Liab.Malpractice	(455)		2,053									1,598	26
27	Other (specify):*				43,166								43,166	27
28	TOTAL General Administration	(200,051)	1,063	(96,417)	234,260								(61,145)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(202,011)	1,063	(86,919)	249,556	(1,249)							(39,559)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr# 0040444

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	19,996	123,087	9,227									152,310	30
31	Amortization of Pre-Op. & Org.	(50,228)	50,228											31
32	Interest	(5,945)	643,645	2,526									640,226	32
33	Real Estate Taxes			3,929									3,929	33
34	Rent-Facility & Grounds		(900,000)										(900,000)	34
35	Rent-Equipment & Vehicles			1,441									1,441	35
36	Other (specify):*													36
37	TOTAL Ownership	(36,177)	(83,040)	17,123									(102,094)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(498)	(34)						(532)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(2,050)											(2,050)	43
44	TOTAL Special Cost Centers	(2,050)				(498)	(34)						(2,582)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(240,237)	(81,977)	(69,796)	249,556	(1,747)	(34)						(144,235)	45

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. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 900,000	Sheridan Shores Property LLC	100.00%	\$	\$ (900,000)	1
2	V	21 Admin Expense		Sheridan Shores Property LLC	100.00%	310	310	2
3	V	21 Bank Charges		Sheridan Shores Property LLC	100.00%	255	255	3
4	V	21 Filing Fees		Sheridan Shores Property LLC	100.00%	498	498	4
5	V	30 Depreciation		Sheridan Shores Property LLC	100.00%	123,087	123,087	5
6	V	31 Amortization		Sheridan Shores Property LLC	100.00%	50,228	50,228	6
7	V	32 Interest - Business Partner		Sheridan Shores Property LLC	100.00%	158,507	158,507	7
8	V	32 Interest - Bank Leumi		Sheridan Shores Property LLC	100.00%	485,138	485,138	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 900,000			\$ 818,023	\$ * (81,977)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	01 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 430	\$	430	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	758		758	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	759		759	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	1,003		1,003	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	6,548		6,548	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	5,020		5,020	20
21	V	19 Professional Fees	144,000	Extended Care Consulting, LLC	100.00%	12,738		(131,262)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	4,483		4,483	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	21,189		21,189	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	575		575	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,525		1,525	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	2,053		2,053	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	9,227		9,227	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	2,526		2,526	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	3,929		3,929	29
30	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,441		1,441	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			\$ 74,204	\$ *	(69,796)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	06 Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	12,483	\$	12,483	15
16	V	06 Maintenance (Direct)	16,925	Extended Care Consulting, LLC	100.00%	16,925			16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,280		1,280	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	1,533		1,533	18
19	V								19
20	V								20
21	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	27,713		27,713	21
22	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	174,463		174,463	22
23	V	21 Office and Clerical (Direct)	20,014	Extended Care Consulting, LLC	100.00%	20,014			23
24	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	37,762		37,762	24
25	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	5,404		5,404	25
26	V	22 Employee Benefits	11,082	Extended Care Consulting, LLC	100.00%			(11,082)	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		\$ 48,021			\$ 297,577	\$ *	249,556	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary Supplies, Supplements	\$ 4,459	Care Centers Health Systems, Inc.	100.00%	\$ 3,211	\$ (1,249)
16	V	10 Nursing Supplies		Care Centers Health Systems, Inc.	100.00%		
17	V	39 Ancillary Expense	1,779	Care Centers Health Systems, Inc.	100.00%	1,281	(498)
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 6,238			\$ 4,491	\$ * (1,747)

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 Ancillary Expense	3,817	Reliable Medical of the Midwest, LLC	100.00%	3,783	\$ (34)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 3,817			\$ 3,783	\$ * (34)

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 98,005	\$ 98,005	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	98,005	CCS Employee Benefits Group	100.00%		(98,005)	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		\$ 98,005			\$ 98,005	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	GALE ROTHNER	15.957%	AVENUE CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	SHERIDAN SHORES PROPERTY	EVANSTON	BUILDING CO.	1
2	ERIC ROTHNER GRANTOR TRUST	29.787%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC BEECHER		EXTENDED CARE CONSULTING	EVANSTON	MANAGEMENT/BOOKK	2
3	NATHAN & SHIRLEY ROTHNER FAMILY TR	54.255%	BOULEVARD CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	EXTENDED CARE CLINICAL	EVANSTON	ADMINISTRATIVE	3
4			BRIAR PLACE LTD	INDIAN HEAD PARK	CARE CENTER HEALTH SYSTE	DES PLAINES	DIETARY & FOOD SUPP	4
5			CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	5
6			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	ROTHNER VENTS LLC	EVANSTON	VENTALATOR RENTAL	6
7			DYER NURSING & REHAB	DYER, IN	CARE CENTERS BUILDING LL	EVANSTON	BLDG COMPANY	7
8			GRASMERE PLACE, LLC	CHICAGO	RELIABLE MEDICAL OF THE M	DES PLAINES	MEDICAL SUPPLIES	8
9			LAKE COUNTY NURSING & REHAB	EAST CHICAGO, IN				9
10			LAKWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD				10
11			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT				11
12			MCKINLEY HEALTH CARE CENTER	CANTON, OH				12
13			OAK PARK HEALTHCARE CENTER, L.L.C.	OAK PARK				13
14			PARC AT JOLIET LLC	JOLIET				14
15			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				15
16			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				16
17			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				17
18			RAINBOW BEACH QOC, L.L.C.	CHICAGO				18
19			SEBOS NURSING & REHAB	HOLBART, IN				19
20			SHEFFIELD MANOR	DYER, IN				20
21			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				21
22			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				22
23			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				23
24			WHEATON CARE CENTER	WHEATON				24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr # 0040444 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Steinberg	Relative	Administrative	0.00%	See Attached	4.35	7.72%	Al Sal/Al Fee	\$ 15,177	17-7	1
2	Adam Vales	Relative	Clerical	0.00%	See Attached	0.91	2.28%	Alloc Salary	1,596	22-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 16,773		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr

0040444

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr

0040444

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,101,784	30	\$ 7,195	\$ 65,847	\$ 430	1
2	02	Food	Patient Days	1,101,784	30	12,684	65,847	758	2
3	03	Housekeeping	Patient Days	1,101,784	30	12,707	65,847	759	3
4	05	Utilities	Patient Days	1,101,784	30	16,778	65,847	1,003	4
5	06	Maintenance	Patient Days	1,101,784	30	109,559	65,847	6,548	5
6	17	Administrative	Patient Days	1,101,784	30	84,000	65,847	5,020	6
7	19	Professional Fees	Patient Days	1,101,784	30	213,139	65,847	12,738	7
8	20	Dues and Subscriptions	Patient Days	1,101,784	30	75,016	65,847	4,483	8
9	21	Office and Clerical	Patient Days	1,101,784	30	354,548	65,847	21,189	9
10	24	Seminar and Travel	Patient Days	1,101,784	30	9,615	65,847	575	10
11	25	Other Staff Admin. Trans.	Patient Days	1,101,784	30	25,510	65,847	1,525	11
12	26	Insurance	Patient Days	1,101,784	30	34,345	65,847	2,053	12
13	30	Depreciation	Patient Days	1,101,784	30	154,393	65,847	9,227	13
14	32	Interest	Patient Days	1,101,784	30	42,261	65,847	2,526	14
15	33	Real Estate Taxes	Patient Days	1,101,784	30	65,749	65,847	3,929	15
16	35	Rent - Equipment & Auto	Patient Days	1,101,784	30	24,117	65,847	1,441	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,241,615	\$	\$ 74,204	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr

0040444

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	06	Maintenance (Pooled)	Patient Days	1,101,784	30	208,870	208,870	65,847	12,483	1
2	06	Maintenance (Direct)	Direct		30	331,520	331,520		16,925	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,101,784	30	21,409		65,847	1,280	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		30	37,937			1,533	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,101,784	30	463,710	463,710	65,847	27,713	7
8	21	Office and Clerical (Pooled)	Patient Days	1,101,784	30	2,919,199	2,919,199	65,847	174,463	8
9	21	Office and Clerical (Direct)	Direct		30	328,534	328,534		20,014	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,101,784	30	631,850		65,847	37,762	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		30	55,508			5,404	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 4,998,538	\$ 4,251,833		\$ 297,577	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr

0040444

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

Name of Related Organization Care Centers Health Systems, Inc.
 Street Address 200 Howard
 City / State / Zip Code Des Plaines, Illinois 60018
 Phone Number (224) 612-5662
 Fax Number (224) 612-5862

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary Supplies, Supplements	Direct Allocation					\$ 3,211	1
2	10	Nursing Supplies	Direct Allocation						2
3	39	Ancillary Expense	Direct Allocation					1,281	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				\$	\$		\$ 4,491	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr

0040444

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

Name of Related Organization Reliable Medical of the Midwest, LLC
 Street Address 200 Howard Avenue
 City / State / Zip Code Des Plaines, Illinois 60018-5909
 Phone Number (847) 566-0800
 Fax Number ()

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Ancillary Expense	Direct Allocation					3,783	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				\$	\$		\$ 3,783	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr

0040444

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 98,005	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				\$	\$		\$ 98,005	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr

0040444

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr

0040444

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr

0040444

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr

0040444

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	Name of Lender	2		3	4	5	6		8	9	10						
		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	Business Partners, LLC		X	Mortgage			\$	\$ 11,517,987			\$ 643,645	1					
2												2					
3												3					
4												4					
5												5					
Working Capital																	
6	DAIWA		X	Line of Credit							1,904	6					
7	Shareholder Loan	X		Line of Credit				222,574				7					
8												8					
9	TOTAL Facility Related						\$	\$ 11,740,561			\$ 645,549	9					
B. Non-Facility Related*																	
10	Interest Income		X								(5,945)	10					
11	Allocated from EC Consulting	X									2,526	11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ (3,419)	14					
15	TOTALS (line 9+line14)						\$	\$ 11,740,561			\$ 642,130	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

Facility Name & ID Number

Sheridan Shores Cr & Reh Ctr

0040444

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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							\$	\$			\$					
2																
3																
4																
5																
6																
7	TOTAL Long-Term															
	Working Capital															
8							\$	\$			\$					
9																
10																
11																
12																
13																
14	TOTAL Working Capital															
	B. Non-Facility Related*															
15							\$	\$			\$					
16																
17																
18																
19																
20	TOTAL Non-Facility Related															

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2012 report.		\$	<u>57,313</u>		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.)		\$	<u>227,652</u>		2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>170,339</u>		3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>111,862</u>		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.)		\$	<u>5,777</u>		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>287,978</u>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2008	<u>196,526</u>	8		
	2009	<u>165,293</u>	9		
	2010	<u>172,489</u>	10		
	2011	<u>171,772</u>	11		
	2012	<u>223,723</u>	12		
2013 Accrual = \$223,723 x 1.05 = \$234,909 - 123,048 (2013 Tax Prepayment) = 111,862					
Beginning Accrual adjusted for the prepayment.					
Allocated from EC Consulting: \$3,929					
				FOR BHF USE ONLY	
				13	13
				14	14
				15	15
				16	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.

SEE ACCOUNTANTS' COMPILATION REPORT

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sheridan Shores Cr & Reh Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040444

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2012 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 2012.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>14-05-402-027-0000</u>	<u>Long Term Care Property</u>	\$ <u>111,861.37</u>	\$ <u>111,861.37</u>
2. <u>14-05-402-028-0000</u>	<u>Long Term Care Property</u>	\$ <u>111,861.37</u>	\$ <u>111,861.37</u>
3. <u>See Attached</u>	<u>Allocation From 2201 Main</u>	\$ <u>133,178.74</u>	\$ <u>3,097.96</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>356,901.48</u></u>	\$ <u><u>226,820.70</u></u>

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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.**

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr

0040444 Report Period Beginning:

01/01/13 Ending:

12/31/13

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 (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? (a) Own the Equipment (b) Rent equipment from a Related Organization. (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 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>			\$ <u>690,923</u>	1
2	<u>Allocated from EC Consulting 2201 Main</u>			<u>19,074</u>	2
3	TOTALS			\$ 709,997	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	191		1977	\$ 4,446,256	\$ 123,087	39	\$ 114,007	\$ (9,080)	\$ 1,031,111	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1993	42,874		20	1,410	1,410	42,868	9
10	Various		1994	57,552		20	2,698	2,698	56,163	10
11	Various		1995	146,433		20	7,322	7,322	136,582	11
12	Various		1996	67,704		20	3,385	3,385	59,560	12
13	Various		1997	53,902		20	2,695	2,695	44,602	13
14	Various		1998	172,679		20	8,634	8,634	134,663	14
15	Various		1999	62,682		20	3,134	3,134	45,635	15
16	Various		2000	149,525		20	7,450	7,450	101,250	16
17	Various		2001	56,462		20	2,823	2,823	36,075	17
18	Various		2002	66,781		20	1,113	1,113	63,942	18
19	Various		2003	90,560		20	1,613	1,613	90,560	19
20	Various		2004	93,862		20	7,453	7,453	84,923	20
21	Various		2005	446,038		20	23,842	23,842	205,394	21
22	Various		2006	105,189		20	9,873	9,873	78,568	22
23	Various		2007	43,478		20	4,134	4,134	30,117	23
24	Various		2008	63,072		20	5,980	5,980	31,788	24
25	Various		2009	305,440		20	20,050	20,050	85,793	25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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		500,000			25,000	25,000	25,000	67
68		77,910			5,285	5,285	52,502	68
69					160,598	(160,598)		69
70		\$ 7,048,400	\$ 288,970		\$ 257,901	\$ (31,069)	\$ 2,437,097	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr

0040444

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 7,048,400	\$ 288,970		\$ 257,901	\$ (31,069)	\$ 2,437,097	1
2	Replaced Burners In Heating Boiler	2010	2,500		20	250	250	1,000	2
3	Rebuild Brick Wall, Brick, Tuckpointing, Concrete, Lighting	2010	9,520		20	952	952	3,808	3
4	Reaplace Boiler Room Storge Tanks	2010	7,485		20	749	749	2,932	4
5	Install Doors In Masonry Walls, Replace Damaged Blocks	2010	4,031		20	403	403	1,478	5
6	Wall A/C Unit	2010	4,310		20	862	862	2,946	6
7	Fire Alarm System Devices	2010	4,481		20	448	448	1,531	7
8	Wiring For Generator	2010	6,307		20	631	631	2,102	8
9	Fire Suppression System	2010	3,006		20	301	301	927	9
10	Used Generator	2010	43,500		20	8,700	8,700	27,550	10
11	Repair Water Leak	2010	4,862		20	486	486	1,742	11
12	Repalce Countertop Laminate On 5Th, 6Th And 7Th Floor	2010	4,763		20	476	476	1,707	12
13	Masonry Repair	2010	14,280		20	1,428	1,428	5,117	13
14	Leak Repair In Kitchen Storage Room	2010	6,533		20	653	653	2,341	14
15	Installation Of New Rental Unit	2011	3,681		20	368	368	1,104	15
16	Sprinkler System Repair	2011	2,854		20	285	285	808	16
17	2 Automatic Transfer Switches	2011	5,156		20	1,031	1,031	2,836	17
18	New Parking Lot Beans & Slab	2011	18,900		20	945	945	2,520	18
19	Replace Doors, Fix Drywall & Tile	2011	5,014		20	501	501	1,337	19
20	Fire Damper Service	2011	5,634		20	563	563	1,455	20
21	Drywall	2011	3,500		20	350	350	904	21
22	Install Fire Dampers	2011	16,350		20	1,635	1,635	3,815	22
23	Satellite Cable Installation	2011	3,099		20	310	310	697	23
24	Garage Structure Repair	2011	32,500		20	3,250	3,250	7,042	24
25	Doors & Walls Installation	2012	10,850		20	1,085	1,085	2,170	25
26	Grids & Tiles Installation	2012	3,955		20	396	396	725	26
27	Supply & Exhaust-Ducting With Fire Dampers Installation	2012	4,850		20	485	485	889	27
28	Control Valve Replacement	2012	4,430		20	443	443	738	28
29	Flooring	2012	12,400		20	1,240	1,240	1,860	29
30	Security Camera System	2012	3,895		20	779	779	1,169	30
31	3 New Volt Circuits & Outlets	2012	2,950		20	295	295	418	31
32	Storage Tank	2012	6,364		20	636	636	902	32
33	Fire Dampers & Exhaust Fan	2012	2,653		20	265	265	332	33
34	TOTAL (lines 1 thru 33)		\$ 7,313,012	\$ 288,970		\$ 289,104	\$ 134	\$ 2,523,999	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 7,313,012	\$ 288,970		\$ 289,104	\$ 134	\$ 2,523,999	1
2	Basement Compressor & Electrical Work	2012	6,244		20	624	624	780	2
3	Replace Copper Piping Accross Basement Ceiling	2012	9,300		20	465	465	504	3
4	Smoke Damper Repairs	2012	4,612		20	231	231	327	4
5	Wiring - Generator To Control	2012	7,000		20	350	350	525	5
6	Install Hot Water Pump	2012	2,706		20	135	135	192	6
7	Repair West Elevation Steel Door	2012	2,695		20	135	135	213	7
8	Wander Security Ssystem	2013	8,814		20	735	735	735	8
9	Install Ceiling Fans In 1St Fl Lounge	2013	11,731		20	978	978	978	9
10	Furnish & Install Floorfolio In Day Room	2013	5,000		20	417	417	417	10
11	Install Fire Alarm Boxes In Elevators	2013	5,335		20	356	356	356	11
12	Install Stairs Rods & Steel Bars On Rail System	2013	3,230		20	188	188	188	12
13	Provide & Install 2 New Fan/Coil Air Conditioners In Security, Re	2013	6,200		20	258	258	258	13
14	Recover The Entire Canopy & Wall Ssystem On Front Patio	2013	10,400		20	347	347	347	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,396,278	\$ 288,970		\$ 294,322	\$ 5,352	\$ 2,529,817	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1		\$ 7,396,278	\$ 288,970		\$ 294,322	\$ 5,352	\$ 2,529,817		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 7,396,278	\$ 288,970		\$ 294,322	\$ 5,352	\$ 2,529,817		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12D, Carried Forward		\$ 7,396,278	\$ 288,970		\$ 294,322	\$ 5,352	\$ 2,529,817	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,396,278	\$ 288,970		\$ 294,322	\$ 5,352	\$ 2,529,817	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9									9
10	Tuckpointing	2013	500,000		20	25,000	25,000	25,000	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Building Company Information Continued								
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		\$ 500,000	\$		\$ 25,000	\$ 25,000	\$ 25,000	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated From Extended Care Consulting 2201 Main LLC	2002	26,285	674	39	674		7,610	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated From Extended Care Consulting	2007	275	14	20	14		96	9
10	Allocated From Extended Care Consulting	2009	164	8	20	8		41	10
11	Allocated From Extended Care Consulting	2010	1,612	81	20	81		322	11
12	Allocated From Extended Care Consulting	2011	580	29	20	29		87	12
13	Allocated From Extended Care Consulting	2012	191	10	20	10		19	13
14									14
15	Allocated From Extended Care Consulting 2201 Main LLC	2002	21,714	1,984	20	1,984		19,863	15
16	Allocated From Extended Care Consulting 2201 Main LLC	2003	25,589	2,339	20	2,339		23,408	16
17	Allocated From Extended Care Consulting 2201 Main LLC	2005	1,271	135	20	135		999	17
18	Allocated From Extended Care Consulting 2201 Main LLC	2009	229	11	20	11		57	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Related Party Information Continued								
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34	TOTAL (12H & 12I lines 1 thru 33)		\$ 77,910	\$ 5,285		\$ 5,285	\$	\$ 52,502	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 320,703	\$ 618	\$ 11,950	\$ 11,332	10	\$ 281,700	71
72	Current Year Purchases	23,618	118	3,431	3,313	10	3,431	72
73	Fully Depreciated Assets	1,206,753	3,207	3,207		10	1,206,753	73
74								74
75	TOTALS	\$ 1,551,074	\$ 3,943	\$ 18,588	\$ 14,645		\$ 1,491,885	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from EC Consulting	2013	\$ 9,262	\$	\$	\$	5	\$ 9,262	76
77										77
78										78
79										79
80	TOTALS			\$ 9,262	\$	\$	\$		\$ 9,262	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)	\$ 9,666,611	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 292,913	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 312,909	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 19,996	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,030,964	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Sheridan Shores Cr & Reh Ctr

0040444

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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: _____ *

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: \$ 8,492

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	\$	\$ 13,631	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 13,631	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 297,558	\$		\$ 297,558	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			10,249			10,249	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			339,419			339,419	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				318,813		318,813	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>					2,492	99,514		102,006	13
14	TOTAL			\$		\$ 649,718	\$ 418,327		\$ 1,068,045	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Cr & Reh Ctr

0040444

Report Period Beginning: 01/01/13

Ending:

12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 54,051	\$ 77,676	1
2	Cash-Patient Deposits	47,737	47,737	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	927,186	927,186	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	221,325	221,325	6
7	Other Prepaid Expenses	6,981	6,981	7
8	Accounts Receivable (owners or related parties)		7,437,976	8
9	Other(specify): <u>See Attached Schedule</u>	2,392,738	2,735,875	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,650,018	\$ 11,454,756	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		690,923	13
14	Buildings, at Historical Cost		4,394,437	14
15	Leasehold Improvements, at Historical Cost	2,163,630	2,715,449	15
16	Equipment, at Historical Cost	958,988	1,546,272	16
17	Accumulated Depreciation (book methods)	(2,472,546)	(4,020,184)	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): <u>See Attached Schedule</u>	4,145,537	4,496,238	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,795,609	\$ 9,823,135	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,445,627	\$ 21,277,891	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 6,444,817	\$ 6,444,817	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	43,979	43,979	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	240,454	240,454	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,777	8,777	31
32	Accrued Real Estate Taxes(Sch.IX-B)	111,862	111,862	32
33	Accrued Interest Payable	123,254	171,858	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	343,778	343,778	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,316,921	\$ 7,365,525	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	222,574	222,574	39
40	Mortgage Payable		11,517,987	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 222,574	\$ 11,740,561	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,539,495	\$ 19,106,086	46
47	TOTAL EQUITY(page 18, line 24)	\$ 906,132	\$ 2,171,805	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,445,627	\$ 21,277,891	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 137,005	1
2	Restatements (describe):		2
3	Prior Year Bad Debt / Allowance Adjustment	(49,438)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 87,567	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	818,565	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)	\$ 818,565	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)	\$ 906,132	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,941,325	1
2	Discounts and Allowances for all Levels	(3,645,313)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,296,012	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,321,620	6
7	Oxygen	3,674	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,325,294	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	323,621	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,083	19
20	Radiology and X-Ray		20
21	Other Medical Services	10,122	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 348,826	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	5,945	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,945	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	477	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 477	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,976,554	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,713,548	31
32	Health Care	3,473,928	32
33	General Administration	2,074,779	33
B. Capital Expense			
34	Ownership	1,361,455	34
C. Ancillary Expense			
35	Special Cost Centers	1,070,095	35
36	Provider Participation Fee	464,184	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,157,989	40
41	Income before Income Taxes (line 30 minus line 40)**	818,565	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 818,565	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 7,482,329	44
45	Private Pay - Net Inpatient Revenue	124,166	45
46	Medicare - Net Inpatient Revenue	(312,158)	46
47	Other-(specify) <u>Hospice</u>	1,675	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,296,012	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Sheridan Shores Cr & Reh Ctr**

0040444

Report Period Beginning: **01/01/13**

Ending:

12/31/13

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	4,076	4,362	\$ 226,822	\$ 52.00	1
2	Assistant Director of Nursing	2,081	2,130	69,733	32.74	2
3	Registered Nurses	14,886	16,552	492,273	29.74	3
4	Licensed Practical Nurses	33,856	36,722	880,621	23.98	4
5	CNAs & Orderlies	79,270	87,700	959,045	10.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,866	9,037	137,331	15.20	8
9	Activity Director	1,455	1,581	29,812	18.86	9
10	Activity Assistants	8,683	9,706	103,522	10.67	10
11	Social Service Workers	19,195	20,697	364,366	17.60	11
12	Dietician					12
13	Food Service Supervisor	2,084	2,133	40,316	18.90	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,581	6,273	74,847	11.93	15
16	Dishwashers	12,497	14,169	143,913	10.16	16
17	Maintenance Workers	14,557	16,023	203,300	12.69	17
18	Housekeepers	21,522	23,531	236,848	10.07	18
19	Laundry	8,450	9,085	95,537	10.52	19
20	Administrator	4,641	5,030	359,639	71.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,821	6,448	88,544	13.73	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	1,706	1,904	22,907	12.03	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	349	357	5,969	16.72	33
34	TOTAL (lines 1 - 33)	248,576	273,440	\$ 4,535,345 *	\$ 16.59	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	353	\$ 16,527	01-03	35
36	Medical Director	Monthly	3,600	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	13,620	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	21,024	12-03	45
46	Other(specify)				46
47	Psychiatrist Consultant	Monthly	21,400	10-03	47
48					48
49	TOTAL (lines 35 - 48)	353	\$ 76,171		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC: \$19,482
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 13,024 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 464,184
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? N/A If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 - c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
 - d. Have vehicle usage logs been maintained? N/A
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
 - g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.