

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0056143

Facility Name: Sheridan Village Nrsg Rhb

Address: 5838 N Sheridan Rd Chicago 60660
Number City Zip Code

County: Cook

Telephone Number: 773-769-2230 Fax # 773-769-3579

HFS ID Number:

Date of Initial License for Current Owners: 06/04/1993

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Mendel S Schneider Telephone Number: 847-933-1274
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2025 to 12/31/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)		(Date)
	(Type or Print Name)		
	(Title)		
Paid Preparer	(Signed)	See Accountant's Report Attached	(Date)
	(Print Name and Title)		
	(Firm Name & Address)	Mendel S Schneider & Associates CPA PC 4051 Old Orchard Rd Skokie Illinois 60076	
	(Telephone)	847-933-1274	Fax # 847-933-1283
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406		
	Phone # (217) 782-1630		

Facility Name & ID Number Sheridan Village Nrsgrh # 0056143 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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 _____					
	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	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	7,662		5,431		343	1,906	495	15,837	8
9	SNF/PED									9
10	ICF		49,985						49,985	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	7,662	49,985	5,431		343	1,906	495	65,822	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 94.42%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒

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 03/01/2019

J. Was the facility purchased or leased after January 1, 1978? YES ☐ Date 03/01/2019 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 63

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31 Fiscal Year: 12/31
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Sheridan Village Nrsg Rhb # 0056143 Report Period Beginning: 01/01/2025 Ending: 12/31/2025
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	574,900	54,100	32,117	661,117		661,117		661,117			1
2	Food Purchase		584,339		584,339		584,339	(1,202)	583,137			2
3	Housekeeping	417,782	82,468	51,671	551,921		551,921		551,921			3
4	Laundry	191,699	22,668		214,367		214,367		214,367			4
5	Heat and Other Utilities			375,289	375,289		375,289	4,368	379,657			5
6	Maintenance	197,347		171,427	368,774		368,774	7,442	376,216			6
7	Other (specify):*											7
8	TOTAL General Services	1,381,728	743,575	630,504	2,755,807		2,755,807	10,608	2,766,415			8
	B. Health Care and Programs											
9	Medical Director			18,200	18,200		18,200		18,200			9
10	Nursing and Medical Records	6,047,154	424,828	253,480	6,725,462		6,725,462		6,725,462			10
10a	Therapy											10a
11	Activities	185,258	36,157		221,415		221,415		221,415			11
12	Social Services	199,742	2,274		202,016		202,016		202,016			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	6,432,154	463,259	271,680	7,167,093		7,167,093		7,167,093			16
	C. General Administration											
17	Administrative	136,991		1,093,454	1,230,445		1,230,445	(1,093,454)	136,991			17
18	Directors Fees											18
19	Professional Services			93,847	93,847		93,847	153,955	247,802			19
20	Dues, Fees, Subscriptions & Promotions			58,737	58,737		58,737	(17,399)	41,338			20
21	Clerical & General Office Expenses	632,367	189,482	417,139	1,238,988		1,238,988	131,391	1,370,379			21
22	Employee Benefits & Payroll Taxes			1,114,191	1,114,191		1,114,191		1,114,191			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,375	3,375		3,375		3,375			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			574,190	574,190		574,190	1,252	575,442			26
27	Other (specify):* Allocated Benefits							33,508	33,508			27
28	TOTAL General Administration	769,358	189,482	3,354,933	4,313,773		4,313,773	(790,747)	3,523,026			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,583,240	1,396,316	4,257,117	14,236,673		14,236,673	(780,139)	13,456,534			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			153,896	153,896		153,896	117,469	271,365			30
31	Amortization of Pre-Op. & Org.			19,370	19,370		19,370		19,370			31
32	Interest							447,233	447,233			32
33	Real Estate Taxes			619,786	619,786		619,786		619,786			33
34	Rent-Facility & Grounds			1,279,266	1,279,266		1,279,266	(1,274,717)	4,549			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Bad Debt			478,805	478,805		478,805	(478,805)				36
37	TOTAL Ownership			2,551,123	2,551,123		2,551,123	(1,188,820)	1,362,303			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		123,513	607,677	731,190		731,190		731,190			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			802,395	802,395		802,395		802,395			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		123,513	1,410,072	1,533,585		1,533,585		1,533,585			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	8,583,240	1,519,829	8,218,312	18,321,381		18,321,381	(1,968,959)	16,352,422			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(38,701)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,202)	2		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	(58,157)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(10,257)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(478,805)	36		24
25	Fund Raising, Advertising and Promotional	(6,321)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(53,465)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (646,908)		\$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,310,973)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,310,973)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,957,881)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (11,078)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
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47				47
48				48
49	Total	(11,078)		49

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

[illegible]

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

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	\$ 1,279,266	Sheridan Shores Property LLC		\$	(1,279,266)	1
2	V	32	Interest				447,233	447,233	2
3	V	30	Depreciation				156,170	156,170	3
4	V	19	Accounting Fees				8,925	8,925	4
5	V	21	Replacement Tax				53,465	53,465	5
6	V	21	Office				38,277	38,277	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,279,266			\$ 704,070	\$ * (575,196)	14

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

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	17	Management Fees	\$ 1,093,454	Jade Financial Services	100.00%	\$	\$ (1,093,454)	15
16	V	21	Office		Jade Financial Services		42,180	42,180	16
17	V	19	Professional Fees		Jade Financial Services		155,287	155,287	17
18	V	5	Utilities		Jade Financial Services		4,368	4,368	18
19	V	6	Repairs & Maintenance		Jade Financial Services		7,442	7,442	19
20	V	34	Rent		Jade Financial Services		4,549	4,549	20
21	V	21	Clerical Wages		Jade Financial Services		109,091	109,091	21
22	V	27	Allocated Benefits		Jade Financial Services		33,508	33,508	22
23	V	26	Insurance		Jade Financial Services		1,252	1,252	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,093,454			\$ 357,677	\$ * (735,777)	39

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

STATE OF ILLINOIS					Ownership Listing-1			
Sheridan Village Nrsrg Rhb								
ID#		0056143						
Report Period Beginning:		01/01/2025						
Ending:		12/31/2025						
-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)					Operator/Licensee	Building Co.	Management Co./Home Office	
-Owners of companies must be listed instead of company names.								
-Names of trust beneficiaries must be listed.								
First Name		M.I.	Last Name	City	State	Ownership Percentage	Ownership Percentage	Ownership Percentage
1	Jake	0	Mashiach	Chicago	IL	23.33000		1
2	Yechiel	0	Mashiach	Lincolnwood	IL	23.33000		2
3	Rhonda	0	Mashiach	Lincolnwood	IL	10.00000		3
4	Rita	0	Lipshitz	Skokie	IL	10.00000		4
5	Atied Associates, L.L.C.	0	0	0	0	0.00000		5
6	B&Z Grandchildren Tru	0	0	0	0	0.00000		6
7	Beneficiaries	0	0	0	0	0.00000		7
8	Rebecca	0	Rudolph	Evanston	IL	0.38469		8
9	Michael	0	Rudolph	Evanston	IL	0.38469		9
10	Zahava	0	Vales	Evanston	IL	0.38469		10
11	Raban	0	Vales	Evanston	IL	0.38469		11
12	Natan	0	Vales	Deerfield	IL	0.38469		12
13	Amidei	0	Vales	Deerfield	IL	0.38469		13
14	Cary	0	Silvers	Evanston	IL	0.38469		14
15	Jonathan	0	Silvers	Highland Park	IL	0.38469		15
16	Jacob	0	Silvers	Highland Park	IL	0.38469		16
17	Noam	0	Rothner	Teaneck	NJ	0.38469		17
18	Yonit	0	Rothner	Teaneck	NJ	0.38469		18
19	Hanna	0	Levine	Skokie	IL	0.38469		19
20	Nathan	0	Levine	Evanston	IL	0.38469		20
21	Nathan & Shirley Rothn	0	0	0	0	0.00000		21
22	Beneficiaries	0	0	0	0	0.00000		22
23	Melisa	0	Rothner	Skokie	IL	1.25025		23
24	Daniel	0	Rothner	Teaneck	NJ	1.25025		24
25	William	0	Rothner	Skokie	IL	1.25025		25
26	Rachel	0	Rothner	Beachwood	OH	1.25025		26
27	0	0	0	0	0	0.00000		27
28	Daniel Rothner Accumu	0	0	0	0	0.00000		28
29	Beneficiaries	0	0	0	0	0.00000		29
30	Daniel	0	Rothner	Teaneck	NJ	1.66700		30
31	William Rothner Accumu	0	0	0	0	0.00000		31
32	Beneficiaries	0	0	0	0	0.00000		32
33	William	0	Rothner	Skokie	IL	1.66700		33
34	Melisa Rothner Accumu	0	0	0	0	0.00000		34
35	Beneficiaries	0	0	0	0	0.00000		35
36	Melisa	0	Rothner	Skokie	IL	1.66700		36
37	Rachel Rothner Accumu	0	0	0	0	0.00000		37
38	Rachel	0	Rothner	Beachwood	OH	1.66700		38
39	Adam Vales Accumulati	0	0	0	0	0.00000		39
40	Adam	0	Vales	Deerfield	IL	1.66700		40
41	Kathryn Vales Accumul	0	0	0	0	0.00000		41
42	kathryn	0	Vales	Highland park	IL	1.66700		42
43	Kimberly Vales Accumu	0	0	0	0	0.00000		43
44	Kimberly	0	Vales	Highland Park	IL	1.66700		44
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Facility Name & ID Number

Sheridan Village Nrsg Rhb

0056143

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

VII. RELATED PARTIES

A. (Continued)

Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Arista Healthcare	Naperville	SALEM NURSING & REHABILITATION CENTER	Joliet	Jade Financial Svc	Skokie, Ill	Mgmt	1
2	Forest City Nursing & Rehab	Rockford	NORTHVIEW VILLAGE INC.	St. Louis				2
3	Rock River Healthcare	Rockford	CHATEAU NURSING & REHABILITATION CENTER	Willowbrook				3
4	Pearl Pavillion	Freeport	GRASMERE PLACE LLC	Chicago				4
5	Parc Of Joliet	Joliet	LAKEWOOD NURSING & REHABILITATION CENTER	Plainfield				5
6	Spring Creek SNF	Joliet	LEMONT NURSING & REHABILITATION CENTER	Lemont				6
7	Chicago Ridge SNF	Chicago ridge	PRARIE MANOR NURSING & REHABILITATION CENTER	Chicago Heights				7
8	Briar place	Indian Head park	FOOTHILLS REHABILITATION CENTER LLC	Tucson				8
9	ELMWOOD NURSING & REHABILITATION CENTER	Maryville	MCKINLEY HEALTH CARE CENTER LLC	Canton				9
10	CRESTWOOD REHABILITATION CENTER INC	Crestwood	DEVON GABLES REHABILITATION CENTER LLC	Tucson				10
11	KENSINGTON NURSING AND REHABILITATION CENTER	Chicago	ST. JAMES WELLNESS REHAB & VILLAS LLC	Crete				11
12	ABBINGTON VILLAGE NURSING AND REHABILITATION CENTER	Roselle	KENSINGTON NURSING HOLDINGS LLC	Chicago				12
13	ALL AMERICAN NURSING AND REHABILITATION CENTER	Chicago	ESTATES OF HYDE PARK LLC	Chicago				13
14	HICKORY VILLAGE NURSING AND REHABILITATION CENTER	Hickory Hills	PONTIAC HEALTHCARE AND REHAB LLC	Pontiac				14
15	HENRY FORD VILLAGE LLC	Dearborn	PINE CREST HEALTH CARE LLC	Hazelcrest				15
16	wheaton Village Nursing & Rehab center	Chicago	APERION CARE KOKOMO LLC	Kokomo				16
17	JB KENOSHA LLC	Kenosha	APERION CARE PERU LLC	Peru				17
18	EDGEWATER CARE & REHABILITATION CENTER	Chicago	APERION CARE TOLLESTON PARK LLC	Gary				18
19	Little Village Nursing & rehab Center	Chicago	APERION CARE DEMOTTE LLC	East Demotte				19
20	RUSHVILLE NURSING REHABILITATION CENTER	Rushville	RUSHVILLE NURSING REHABILITATION CENTER	Rushville				20
21	NEIGHBORS REHABILITATION CENTER LLC	Byron	BRIDGEWAY SENIOR LIVING LLC	Bensenville				21
22	CHAMPAIGN REHABILITATION CENTER LLC	Champaign	PARK VILLA NURSING & REHABILITATION CENTER	Palos Heights				22
23	Westwood Village Nursing & Rehab Center	Chicago	WESTMONT MANOR HRC LLC	Westmont				23
24	WESTWOOD VILLAGE NURSING AND REHABILITATION CENTER	Chicago	SOUTH HOLLAND MANOR LLC	South Holland				24
25	Tri State Village & Nursing Center	Chicago	UNIVERSITY REHABILITATION CENTER	Urbana				25
26			PALOS HEIGHTS REHABILITATION LLC	Crestwood				26
27			BURBANK REHABILITATION CENTER LLC	Burbank				27
28			COUNTRYSIDE NURSING & REHABILITATION CENTER	Dolton				28
29								29
30								30

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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Sheridan Village Nrsg Rhb # 0056143 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Jade Financial Services LLC
Street Address 8707 Skokie Blvd
City / State / Zip Code Skokie, IL 60077
Phone Number (847) 213-1060
Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	21	Office	Number of Beds	1,231	10	\$ 271,852	\$	191	\$ 42,180	1
2	19	Professional Fees	Number of Beds	1,231	10	1,000,830		191	155,287	2
3	5	Utilities	Number of Beds	1,231	10	28,149		191	4,368	3
4	6	Repairs & Maintenance	Number of Beds	1,231	10	47,967		191	7,442	4
5	34	Rent	Number of Beds	1,231	10	29,319		191	4,549	5
6	21	Clerical Wages	Number of Beds	1,231	10	703,094	703,094	191	109,091	6
7	27	Allocated Benefits	Number of Beds	1,231	10	215,961		191	33,508	7
8	26	Insurance	Number of Beds	1,231	10	8,068		191	1,252	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					\$ 2,305,240	\$ 703,094		\$ 357,677	25

Facility Name & ID Number Sheridan Village Nrsg Rhb # 0056143 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Interntl Bk of Chicago		X	Mortgage			\$	6,436,259			\$	447,233	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$	6,436,259			\$	447,233	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$		14
15	TOTALS (line 9+line14)						\$	6,436,259			\$	447,233	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	691,464	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.)				\$	629,332	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(62,132)	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	641,918	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.)				\$	40,000	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.				\$		6
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.				\$	619,786	7
Assessed Value from Real Estate Tax Bill:	2024	3,132,440	8			
Real Estate Tax Bill for Calendar Year:	2020	363,267	9			
	2021	627,640	10			
	2022	641,970	11			
	2023	658,537	12			
	2024	629,332	13			
Line 4: 629332 x 1.02				14	FROM R. E. TAX STATEMENT FOR 2024 \$	14
				15	PLUS APPEAL COST FROM LINE 5 \$	15
				16	LESS REFUND FROM LINE 6 \$	16
				17	AMOUNT TO USE FOR RATE CALCULATION \$	17

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.

FACILITY NAME	Sheridan Village Nrsg Rhb	COUNTY	Cook
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CONTACT PERSON REGARDING THIS REPORT Judd Schneider

A. Summary of Real Estate Tax Cost

[illegible]

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 74,000 B. General Construction Type: Exterior Brick Frame Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (X) (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (X) (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).

F. List the bed capacity for the building if it differs from the licensed total.
G. Have you properly capitalized all major repairs and equipment purchases?
H. Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement?
J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? (X) YES NO
If so, please complete the following:

1. Total Amount Incurred: 96,851 2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 19,370 4. Dates Incurred: 06/30/24

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility			\$ 690,923	1
2					2
3	TOTALS			\$ 690,923	3

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		2019	1977	\$ 4,446,256	\$ 154,077	39	\$ 114,007	\$ (40,070)	\$ 2,399,195
5										
6										
7										
8										
	Improvement Type**									
9	Various		1993		42,874		20			42,874
10	Various		1994		57,552		20			57,552
11	Various		1995		146,433		20			146,433
12	Various		1996		67,704		20			67,704
13	Various		1997		53,902		20			53,902
14	Various		1998		172,679		20			172,679
15	Various		1999		62,682		20			62,682
16	Various		2000		149,525		20			149,525
17	Various		2001		56,462		20			56,462
18	Various		2002		66,781		20			66,781
19	Various		2003		88,238		20			88,238
20	Various		2004		93,861		20			93,861
21	Various		2005		446,038		20	20,389	20,389	454,361
22	Various		2006		105,190		20			105,190
23	Various		2007		43,478		20			43,478
24	Various		2008		63,072		20	280	280	62,255
25	Various		2009		299,085		20	12,489	12,489	250,168
26	Various		2010		115,578		20			115,578
27	Various		2011		96,688		20	945	945	91,648
28	Various		2012		78,540		20	2,824	2,824	74,054
29	Various		2013		50,710		20			50,710
30	Various		2014		131,805		20	6,592	6,592	87,057
31	Various		2015		8,625		20	431	431	4,488
32	Various		2016		89,770		20	4,488	4,488	43,414
33	Various		2017		26,441		20	1,323	1,323	11,491
34	Various		2018		38,435		20	1,923	1,923	14,861
35										
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Sheridan Village Nrsg Rhb

0056143

Report Period Beginning:

01/01/2025 Ending: 12/31/2025

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	
37	Overhead Door Installation	2019	\$ 3,435	\$	20	\$ 172	\$ 172	\$ 1,204	37
38	Luxury Vinyl Plank Flooring	2019	3,150		20	158	158	1,105	38
39	Security System Thru Facility	2019	14,342		20	717	717	5,019	39
40	Repaved Parking Lot	2020	6,792		20	340	340	2,040	40
41	Architect Fee Relating to Parking Deck Repairs	2020	5,845		20	292	292	1,752	41
42	Water Heater Repair	2020	5,980		20	299	299	1,794	42
43	Plumbing Repair	2020	9,000		20	450	450	2,700	43
44	Cable Installation for Security	2020	14,539		20	727	727	4,362	44
45	Smoke/Fire Damper Repair	2020	17,300		20	865	865	5,190	45
46	Fire Rate Doors & Frame	2020	10,638		20	532	532	3,192	46
47	Cabling for Overhead Paging System	2020	4,703		20	235	235	1,410	47
48	Annunciators , Switches, Call lights-Bathroom	2020	10,238		20	512	512	3,072	48
49	Generator Repairs	2020	2,755		20	138	138	828	49
50	Generator-Control Board, Module Board	2020	3,106		20	155	155	930	50
51	Condensor Pump Repair	2020	2,674		20	134	134	804	51
52	Cooling Tower Chiller Repair	2020	4,697		20	235	235	1,410	52
53	Air Flow System for Patio	2020	2,655		20	133	133	798	53
54	9.5K BTU 155V Cool HVAC Units	2020	12,967		20	648	648	3,888	54
55	Sink Replacement in Kitchen	2020	4,000		20	200	200	1,200	55
56	Room Cubicle Curtains	2020	18,432		20	1,016	1,016	6,096	56
57	Architect Fees-Parking Deck Replacement	2021	8,533		20	427	427	2,135	57
58	Install Circuit Breaker	2021	8,500		20	425	425	2,125	58
59	Compressor	2021	14,300		20	715	715	3,575	59
60	Elevator Cab & Door Replacement	2021	12,260		20	613	613	3,065	60
61	New Tubes,Gaskets in Boiler	2021	15,700		20	785	785	3,925	61
62	Architect-Life Safety Corrections	2021	2,716		20	136	136	680	62
63	1st Fl Dayroom Heating & Cooling	2021	11,600		20	580	580	2,900	63
64	Door System	2021	4,220		20	211	211	1,055	64
65	Parking deck Replacement	2021	595,696		20	29,867	29,867	149,335	65
66	New Compressor In Walk in Freezer	2021	5,076		20	254	254	1,270	66
67	Installation of New Magnetic Lock	2021	4,613		20	231	231	1,155	67
68	Roof Repair	2021	2,950		20	148	148	740	68
69		2021	2,810		20	140	140	700	69
70	TOTAL (lines 4 thru 69)		\$ 7,944,626	\$ 154,077		\$ 208,181	\$ 54,104	\$ 5,088,095	70

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

Facility Name & ID Number Sheridan Village Nrsg Rhb

0056143

Report Period Beginning:

01/01/2025 Ending: 12/31/2025

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 12A, Carried Forward		\$ 7,944,626	\$ 154,077		\$ 208,181	\$ 54,104	\$ 5,088,095	1
2	Fire Alarm System Repair	2021	3,123		20	156	156	780	2
3	Large Elevator Repair	2021	3,512		20	176	176	880	3
4	New boiler Gate Valve & Gaskets	2021	3,394		20	170	170	850	4
5	Replace Cooling Tower Pump Motor	2021	2,501		20	125	125	625	5
6	Repair Water Pump	2021	4,232		20	212	212	848	6
7	Install 18 New Cameras in Staircase	2022	11,186		20	559	559	2,236	7
8	Install Alarms	2022	17,835		20	892	892	3,568	8
9	Don & Mds office Cabintry	2022	27,000		20	1,350	1,350	5,400	9
10	Through Wall A/C	2022	4,028		20	201	201	804	10
11	Flooring	2022	4,680		20	234	234	936	11
12	Replace Outlets	2022	16,418		20	821	821	3,284	12
13	Replace Underground Piping & Booster Pump	2022	21,600		20	1,080	1,080	4,320	13
14	Fire System Sprinkler Repair	2022	13,237		20	662	662	2,648	14
15	Aluminum Pederstrian Door Installations	2022	11,425		20	571	571	2,284	15
16	Railing Painting	2022	8,250		20	413	413	1,652	16
17	Door Replacement	2022	14,800		20	740	740	2,960	17
18	Replace Lighting in Parking Lot	2022	13,270		20	664	664	2,656	18
19	Cast Iron Piping	2022	9,800		20	490	490	1,960	19
20	replace Boiler Burners	2022	3,860		20	193	193	772	20
21	Replace Laundry Chute Door	2022	2,517		20	126	126	504	21
22	7th Floor Shower Repiping	2022	4,800		20	240	240	960	22
23	Replace Control Unit Call Lights	2022	3,595		20	180	180	720	23
24	Replace Elewvators	2022	14,903		20	745	745	2,980	24
25	Replace Utility Sinks	2022	6,850		20	343	343	1,372	25
26	Remove & Replace Sewer Pipe	2022	6,500		20	325	325	1,300	26
27	New Interior Sign	2022	3,061		20	153	153	612	27
28	Sight Guard Replacement on Elevator	2022	2,665		20	133	133	532	28
29	New Motors for Bathroom Exhaust Fans	2022	3,464		20	173	173	692	29
30	Repipe 3rd Floor Shower	2022	6,800		20	340	340	1,360	30
31	Replace Cast iron drain Line	2022	3,200		20	160	160	640	31
32	replace Cast Iron Pipes	2022	3,800		20	190	190	760	32
33	Replace Shower Valves & Change Pipe to Copper	2022	2,800		20	140	140	560	33
34	TOTAL (lines 1 thru 33)		\$ 8,203,732	\$ 154,077		\$ 221,138	\$ 67,061	\$ 5,140,550	34

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

Facility Name & ID Number Sheridan Village Nrsg Rhb

0056143

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

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 12B, Carried Forward		\$ 8,203,732	\$ 154,077		\$ 221,138	\$ 67,061	\$ 5,140,550	1
2	Bath & Shower Repair to 6 Floors	2023	6,020		15	401	401	1,203	2
3	New Door Systems	2023	20,650		15	1,377	1,377	4,131	3
4	Seco Refrigeration Repairs	2023	27,647		15	1,843	1,843	5,529	4
5	New Cooling Tower	2024	56,000		15	3,733	3,733	7,466	5
6	2 New Hollow Metal Doors to Kitchen	2024	9,454		15	630	630	1,260	6
7	Repipe Cold water Feed in Boiler	2024	4,448		15	297	297	594	7
8	Installed 4 New Tubes and 2 New Pilot Assemblies in Boiler	2024	7,708		15	514	514	1,028	8
9	Installed 2 New Baseboard Heaters in Room 207-208	2024	5,335		15	356	356	712	9
10	Boiler Drain Leak,Reassemble Boiler	2024	27,213		15	1,814	1,814	3,628	10
11	Main Bathroom Pipe Replaced from First to Second Floor	2024	7,200		15	480	480	960	11
12	Main Isolation Valves Replaced in Kitchen Ceiling	2024	3,600		15	240	240	480	12
13	New Walk In Freezer	2024	6,450		15	430	430	860	13
14	Heating Repair	2025	4,467		15	298	298	298	14
15	Repair Leaking Boiler	2025	16,384		15	1,092	1,092	1,092	15
16	Replace Baseboard Heating Rooms-202,204,205,209,212	2025	15,122		15	1,008	1,008	1,008	16
17	Replace Baseboard Heating Rooms-408	2025	3,879		15	259	259	259	17
18	Replace Board in Elevator 2	2025	5,027		15	335	335	335	18
19	Fire Pump Repair,Install Replacement Check Valve	2025	3,010		15	201	201	201	19
20	Replace Door Operator Belt in Each Elevator	2025	4,525		15	302	302	302	20
21	Install New Hot Water Boiler	2025	20,622		15	1,375	1,375	1,375	21
22	Replace Damaged Cast Iron Map-Sink & Drain	2025	5,350		15	357	357	357	22
23	Replace Door Room 404	2025	3,737		15	249	249	249	23
24	Install 2 Additional Fan Coil Cabinets	2025	21,400		15	1,427	1,427	1,427	24
25	Service Door West Elevator	2025	11,641		15	776	776	776	25
26	Replace Fuse A/C Chiller	2025	8,971		15	598	598	598	26
27	Replace Leaking Pipe From 2 Floor to First Floor	2025	6,775		15	452	452	452	27
28	Replace Baseboard Heater Room 308,301,508,201,709,609,509	2025	30,679		15	2,045	2,045	2,045	28
29									29
30									30
31									31
32	Financial Statement Depreciation			155,989			(155,989)		32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,547,046	\$ 310,066		\$ 244,027	\$ (66,039)	\$ 5,179,175	34

**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	\$ 273,380	\$	\$ 27,338	\$ 27,338	10	\$ 259,936	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	1,346,599					1,346,599	73
74								74
75	TOTALS	\$ 1,619,979	\$	\$ 27,338	\$ 27,338		\$ 1,606,535	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 10,857,948	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 310,066	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 271,365	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (38,701)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,785,710	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____
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	Allocated From Jade				4,549			6
7	TOTAL				\$ 4,549			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.
9. Option to Buy: ☐ YES ☐ NO Terms: _____*

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: \$ _____ Description: _____
(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			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	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.

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.	/2026	\$
13.	/2027	\$
14.	/2028	\$

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 247,032	\$		\$ 247,032	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			70,357			70,357	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			290,288			290,288	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				54,550		54,550	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab & Xray	39-2					68,963		68,963	12
13	Other (specify):									13
14	TOTAL			\$		\$ 607,677	\$ 123,513		\$ 731,190	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.

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 217,900	\$ 286,346	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,989,813	2,989,813	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	340,129	340,129	7
8	Accounts Receivable (owners or related parties)	1,872,340	1,873,340	8
9	Other(specify): Due From Others	427,960	6,599,646	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,848,142	\$ 12,089,274	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		680,077	13
14	Buildings, at Historical Cost		4,894,437	14
15	Leasehold Improvements, at Historical Cost	1,956,393	2,055,782	15
16	Equipment, at Historical Cost	174,422	761,706	16
17	Accumulated Depreciation (book methods)	(472,783)	(4,456,428)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	96,851	96,851	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(56,066)	(56,066)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,698,817	\$ 3,976,359	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,546,959	\$ 16,065,633	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,462,167	\$ 2,462,167	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	234,194	234,194	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,856	16,856	31
32	Accrued Real Estate Taxes(Sch.IX-B)	641,918	641,918	32
33	Accrued Interest Payable		21,177	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,355,135	\$ 3,376,312	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,436,259	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)	\$	\$ 6,436,259	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,355,135	\$ 9,812,571	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,191,824	\$ 6,253,062	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,546,959	\$ 16,065,633	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,505,283	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,505,283	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,686,541	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,686,541	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)	\$ 4,191,824	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Sheridan Village Nrsg Rhb

0056143

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

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	\$ 20,007,922	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 20,007,922	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 20,007,922	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,755,807	31
32	Health Care	7,167,093	32
33	General Administration	4,313,773	33
	B. Capital Expense		
34	Ownership	2,551,123	34
	C. Ancillary Expense		
35	Special Cost Centers	731,190	35
36	Provider Participation Fee	802,395	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 18,321,381	40
41	Income before Income Taxes (line 30 minus line 40)**	1,686,541	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,686,541	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 2,030,807.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	14,386,438.00	45
46	MMAI-Medicaid is the Primary Payer	882,575.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	90,835.00	48
49	Medicare Part A	1,498,052.00	49
50	Other-(specify) Medicare-B	438,607.00	50
51	Other-(specify) Misc	254,581.00	51
52	Other-(specify) Insurance	426,027.00	52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 20,007,922	56

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	1,856	2,213	\$ 142,603	\$ 64.44	1
2	Assistant Director of Nursing					2
3	Registered Nurses	27,283	29,232	1,466,098	50.15	3
4	Licensed Practical Nurses	29,172	30,947	1,359,096	43.92	4
5	CNAs & Orderlies	95,100	103,250	2,877,415	27.87	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,645	1,868	39,218	20.99	9
10	Activity Assistants	6,316	7,285	146,040	20.05	10
11	Social Service Workers	6,928	7,241	199,742	27.58	11
12	Dietician					12
13	Food Service Supervisor	4,063	4,415	106,722	24.17	13
14	Head Cook	5,975	6,667	176,265	26.44	14
15	Cook Helpers/Assistants	12,297	13,948	291,913	20.93	15
16	Dishwashers					16
17	Maintenance Workers	5,962	6,632	197,347	29.76	17
18	Housekeepers	19,201	20,922	417,782	19.97	18
19	Laundry	7,603	8,405	191,699	22.81	19
20	Administrator	1,928	2,080	136,991	65.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	21,471	23,747	632,367	26.63	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,170	2,370	67,790	28.60	31
32	Other Health Care(specify)					32
33	Other(specify) MDS	3,096	3,350	134,152	40.05	33
34	TOTAL (lines 1 - 33)	252,066	274,572	\$ 8,583,240 *	\$ 31.26	34

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	Monthly	\$ 32,117	1-3	35
36	Medical Director	Monthly	18,200	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	12,000	10-3	38
39	Pharmacist Consultant	Monthly	14,016	10-3	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				45
46	Other(specify)				46
47	RN Consultant	Monthly	89,462	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 165,795		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	8	\$ 479	10-3	50
51	Licensed Practical Nurses	2,302	126,594	10-3	51
52	Certified Nurse Assistants/Aides	312	10,929	10-	52
53	TOTAL (lines 50 - 52)	2,622	\$ 138,002		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Camille Rolle	Administrator	0	\$ 136,991
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 136,991
B. Administrative - Other			
Description			Amount
Jade Financial-Mgmt Fees			\$ 1,093,454
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,093,454
C. Professional Services			
Vendor/Payee	Type		Amount
Mendel Schneider Cpa	Accounting		\$ 10,400
Neil Gerber	Legal		5,808
Much Shelist	Legal		840
Sher LLP	Legal		3,246
SLR LOC	Legal		2,880
Settlement	Adjusted Out		10,257
Elizabeth Nash	Reimb Cons		28,800
Guided Care	Case Mgmt		19,800
Goodnicki LLP	Legal		3,932
Stout	Appraisal		5,514
Callahan	Legionella Testing		2,370
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 93,847
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 82,446
Unemployment Compensation Insurance			35,438
FICA Taxes			653,704
Employee Health Insurance			342,603
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,114,191
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$ 1,990
Advertising: Employee Recruitment			3,052
Health Care Worker Background Check (Indicate # of checks performed _____)			1,669
Patient Background Checks			440
Association Dues (total from pg 22, #4)			33,234
Netsmart			3,828
RADAR			2,670
Various			5,533
Less: Public Relations Expense		(	)
PAC and Lobbying payments			(11,078)
All non-allowable advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 41,338
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			
Various			3,375
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 3,375

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

Yes
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
HEALTH CARE COUNCIL OF IL (HCCI)	22,156
	22,156 Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

HEALTH CARE COUNCIL OF IL (HCCI)	11,078
	11,078 Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

HEALTH CARE COUNCIL OF IL (HCCI)	33,234
	33,234 Total
- (5)

Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$	59,495	Line	10
----	--------	------	----
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$	802,395
----	---------

This amount is to be recorded on line 42 of Schedule V.
- (8)

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.

- (9)

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
- (10)

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.
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$		Has any meal income been offset against related costs?	Indicate the amount.	\$	
----	--	--	----------------------	----	--
- (12)

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?

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

d. Have vehicle usage logs been maintained?

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

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?

Indicate the amount of income earned from providing such transportation during this reporting period.

\$
- (13)

Has an audit been performed by an independent certified public accounting firm?

No

Firm Name:
- (14)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes
- (15)

Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

Yes

Attach invoices and a summary of services for all architect and appraisal fees.