FOR BHF USE

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: 0045815

Facility Name: Chicago Ridge Nursing Center

Address: 10602 Southwest Highway (Number) Chicago Ridge (City) 60415 (Zip Code)

County: Cook

Telephone Number: (773) 252-3208 **Fax #** (773) 252-3688

HFS ID Number:

Date of Initial License for Current Owners: 11/01/2001

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Sanford B. Alper **Telephone Number:** (847) 580-4100
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 01/01/2012 to 12/31/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Sanford B. Alper, Principal
(Firm Name & Address) Kessler, Orlean, Silver & Company, P.C., 1101 Lake Cook Road, Suite C, Deerfield IL 60015
(Telephone) (847) 580-4100 Fax # (847) 580-4199

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 231

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	231	Skilled (SNF)	231	84,546	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	231	TOTALS	231	84,546	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	68,803	2,851	8,364	80,018	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	68,803	2,851	8,364	80,018	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.64%

D. How many bed-hold days during this year were paid by the Department?
1,705 (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)
N/A

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/2001

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/2001 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 38 and days of care provided 4,616

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	313,869	25,398	9,998	349,265		349,265	25,000	374,265			1
2	Food Purchase		365,231		365,231		365,231	(825)	364,406			2
3	Housekeeping	274,695	25,978		300,673		300,673		300,673			3
4	Laundry	101,568	8,503		110,071		110,071		110,071			4
5	Heat and Other Utilities			174,728	174,728		174,728	6,529	181,257			5
6	Maintenance	29,741	50,484		80,225		80,225	184,648	264,873			6
7	Other (specify):* Attached Schedule			21,991	21,991		21,991	178	22,169			7
8	TOTAL General Services	719,873	475,594	206,717	1,402,184		1,402,184	215,530	1,617,714			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,861,950	81,968	371,926	2,315,844		2,315,844		2,315,844			10
10a	Therapy											10a
11	Activities	107,714	182		107,896		107,896		107,896			11
12	Social Services	245,755	81,194	6,251	333,200		333,200		333,200			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,215,419	163,344	378,177	2,756,940		2,756,940		2,756,940			16
	C. General Administration											
17	Administrative	58,096		1,003,324	1,061,420		1,061,420	(468,743)	592,677			17
18	Directors Fees											18
19	Professional Services			76,374	76,374		76,374	48,585	124,959			19
20	Dues, Fees, Subscriptions & Promotions			7,190	7,190		7,190	1,583	8,773			20
21	Clerical & General Office Expenses	37,157		98,401	135,558		135,558	142,949	278,507			21
22	Employee Benefits & Payroll Taxes			393,495	393,495		393,495	67,125	460,620			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,485	1,485		1,485		1,485			24
25	Other Admin. Staff Transportation			219	219		219	160	379			25
26	Insurance-Prop.Liab.Malpractice			5,395	5,395		5,395	249,085	254,480			26
27	Other (specify):*											27
28	TOTAL General Administration	95,253		1,585,883	1,681,136		1,681,136	40,744	1,721,880			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,030,545	638,938	2,170,777	5,840,260		5,840,260	256,274	6,096,534			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.

Facility Name & ID Number Chicago Ridge Nursing Center #0045815 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			28,379	28,379		28,379	450,899	479,278			30
31	Amortization of Pre-Op. & Org.							192,930	192,930			31
32	Interest			42	42		42	920,558	920,600			32
33	Real Estate Taxes							514,643	514,643			33
34	Rent-Facility & Grounds			1,860,000	1,860,000		1,860,000	(1,860,000)				34
35	Rent-Equipment & Vehicles			2,423	2,423		2,423	925	3,348			35
36	Other (specify):*											36
37	TOTAL Ownership			1,890,844	1,890,844		1,890,844	219,955	2,110,799			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		223,893	391,054	614,947		614,947		614,947			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			928,437	928,437		928,437		928,437			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		223,893	1,319,491	1,543,384		1,543,384		1,543,384			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,030,545	862,831	5,381,112	9,274,488		9,274,488	476,229	9,750,717			45

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
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	(825)	2		13
14	Non-Care Related Interest	(5,091)	32		14
15	Non-Care Related Owner's Transactions	(2,111)	25		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(750)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(48)	20		28
29	Other-Attach Schedule	(438)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (9,263)		$	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)			34
35	Other- Attach Schedule	485,492		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 485,492		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 476,229		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

Chicago Ridge Nursing Center

ID# 0045815

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Contributions - Management Company	$ (106)	21	1
2	Sales Taxes - Management Company	(332)	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				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**	(438)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Chicago Ridge Nursing Center **#** 0045815 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	25,000	0	0	0	0	0	0	0	0	25,000	1
2	Food Purchase	(1,157)	0	332	0	0	0	0	0	0	0	0	(825)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	6,529	0	0	0	0	0	0	0	0	0	6,529	5
6	Maintenance	0	2,830	181,818	0	0	0	0	0	0	0	0	184,648	6
7	Other (specify):*	0	0	178	0	0	0	0	0	0	0	0	178	7
8	**TOTAL General Services**	(1,157)	9,359	207,328	0	0	0	0	0	0	0	0	215,530	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(468,743)	0	0	0	0	0	0	0	0	(468,743)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	45,513	3,072	0	0	0	0	0	0	0	48,585	19
20	Fees, Subscriptions & Promotions	(48)	1,506	125	0	0	0	0	0	0	0	0	1,583	20
21	Clerical & General Office Expenses	(856)	4,512	138,882	411	0	0	0	0	0	0	0	142,949	21
22	Employee Benefits & Payroll Taxes	0	49,482	17,643	0	0	0	0	0	0	0	0	67,125	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(2,111)	160	2,111	0	0	0	0	0	0	0	0	160	25
26	Insurance-Prop.Liab.Malpractice	0	1,303	247,782	0	0	0	0	0	0	0	0	249,085	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(3,015)	56,963	(16,687)	3,483	0	0	0	0	0	0	0	40,744	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(4,172)	66,322	190,641	3,483	0	0	0	0	0	0	0	256,274	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Chicago Ridge Nursing Center **#** 0045815 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	2,174	448,725	0	0	0	0	0	0	0	450,899	30
31	Amortization of Pre-Op. & Org.	0	0	0	192,930	0	0	0	0	0	0	0	192,930	31
32	Interest	(5,091)	7	0	925,642	0	0	0	0	0	0	0	920,558	32
33	Real Estate Taxes	0	0	504,058	10,585	0	0	0	0	0	0	0	514,643	33
34	Rent-Facility & Grounds	0	0	33,317	(1,893,317)	0	0	0	0	0	0	0	(1,860,000)	34
35	Rent-Equipment & Vehicles	0	0	925	0	0	0	0	0	0	0	0	925	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(5,091)	7	540,474	(315,435)	0	0	0	0	0	0	0	219,955	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(9,263)	66,329	731,115	(311,952)	0	0	0	0	0	0	0	476,229	45

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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
Marvin Mermelstein	30.20	RREM, Inc. d/b/a Winston Manor Nursing Home	Chicago	Nivram Mngmt, Inc.	Lincolnwood	Management
Joseph Mermelstein	5.20	Balmoral Home	Chicago	BM of Chicago Ridge	Lincolnwood	Lessor
Barry Taerbaum	25.00					
Marvin Mermelstein Family Trust	19.80					
Joseph A. Mermelstein Family Trust	19.80					

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

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

1	Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	25	Auto Expense	$	Nivram Management, Inc.	50.00%	$ 160	$ 160	1
2	V	20	Advertising		Nivram Management, Inc.	50.00%	317	317	2
3	V	21	Bank Charge		Nivram Management, Inc.	50.00%	35	35	3
4	V	6	Reapairs and Maintenance		Nivram Management, Inc.	50.00%	2,830	2,830	4
5	V	5	Utilities		Nivram Management, Inc.	50.00%	6,529	6,529	5
6	V	21	Delivery Expense		Nivram Management, Inc.	50.00%	230	230	6
7	V	21	Contributions		Nivram Management, Inc.	50.00%	106	106	7
8	V	21	Office Expense		Nivram Management, Inc.	50.00%	4,031	4,031	8
9	V	20	Dues and Subscriptions		Nivram Management, Inc.	50.00%	1,189	1,189	9
10	V	21	Taxes - Other		Nivram Management, Inc.	50.00%	110	110	10
11	V	32	Interest Expense		Nivram Management, Inc.	50.00%	7	7	11
12	V	22	Payroll Taxes		Nivram Management, Inc.	50.00%	49,482	49,482	12
13	V	26	Insurance Expense		Nivram Management, Inc.	50.00%	1,303	1,303	13
14	Total			$			$ 66,329	$ * 66,329	14

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Health Insurance	$	Nivram Management, Inc.	50.00%	$ 17,643	$ 17,643	15
16	V	7	Scavenger		Nivram Management, Inc.	50.00%	178	178	16
17	V	35	Equipment Rental		Nivram Management, Inc.	50.00%	925	925	17
18	V	2	Sales Taxes		Nivram Management, Inc.	50.00%	332	332	18
19	V	21	Postgage		Nivram Management, Inc.	50.00%	531	531	19
20	V	20	Licenses and Permits		Nivram Management, Inc.	50.00%	125	125	20
21	V	25	Travel Expense		Nivram Management, Inc.	50.00%	2,111	2,111	21
22	V	30	Depreciation		Nivram Management, Inc.	50.00%	2,174	2,174	22
23	V	21	Data Processing		Nivram Management, Inc.	50.00%	873	873	23
24	V	21	Telephone		Nivram Management, Inc.	50.00%	2,839	2,839	24
25	V	6	Plant Salary		Nivram Management, Inc.	50.00%	83,664	83,664	25
26	V	17	Assistant Administrator Salary		Nivram Management, Inc.	50.00%	125,496	125,496	26
27	V	21	Office Manager Salary		Nivram Management, Inc.	50.00%	40,034	40,034	27
28	V	1	Food Service Supervisor Salary		Nivram Management, Inc.	50.00%	25,000	25,000	28
29	V	17	Administrative Salaries		Nivram Management, Inc.	50.00%	108,832	108,832	29
30	V	17	Administrator Salary		Nivram Management, Inc.	50.00%	300,253	300,253	30
31	V	21	Clerical Salary		Nivram Management, Inc.	50.00%	94,515	94,515	31
32	V	6	Maintenance Salary		Nivram Management, Inc.	50.00%	98,154	98,154	32
33	V	34	Rent Expense		Nivram Management, Inc.	50.00%	33,317	33,317	33
34	V	17	Management Fees	1,003,324	Nivram Management, Inc.	50.00%		(1,003,324)	34
35	V	21	Bank Charges		BM of Chicago Ridge Real Estate, LLC		90	90	35
36	V	19	Accounting Fees		BM of Chicago Ridge Real Estate, LLC		45,513	45,513	36
37	V	33	Real Estate Taxes		BM of Chicago Ridge Real Estate, LLC		504,058	504,058	37
38	V	26	Insurance Expense		BM of Chicago Ridge Real Estate, LLC		247,782	247,782	38
39	Total			$ 1,003,324			$ 1,734,439	$ * 731,115	39

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Other Taxes	$	BM of Chicago Ridge Real Estate, LLC		$ 250	$ 250	15
16	V	32	Mortgage Interest		BM of Chicago Ridge Real Estate, LLC		926,559	926,559	16
17	V	30	Depreciation Expense		BM of Chicago Ridge Real Estate, LLC		440,571	440,571	17
18	V	31	Amortization		BM of Chicago Ridge Real Estate, LLC		192,930	192,930	18
19	V	34	Rental Income	1,860,000	BM of Chicago Ridge Real Estate, LLC			(1,860,000)	19
20	V	32	Interest Income	917	BM of Chicago Ridge Real Estate, LLC			(917)	20
21	V	34	Rental Income	33,317	Hamlin & Arthur Partnership			(33,317)	21
22	V	21	Bank Fees		Hamlin & Arthur Partnership		161	161	22
23	V	30	Depreciation Expense		Hamlin & Arthur Partnership		8,154	8,154	23
24	V	19	Legal Fees		Hamlin & Arthur Partnership		3,072	3,072	24
25	V	33	Real Estate Taxes		Hamlin & Arthur Partnership		10,585	10,585	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			$ 1,894,234			$ 1,582,282	$ * (311,952)	39

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES

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

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Henry Mermelstein	Administrator	Administrative	0.00	162,137	13	33.33	Salary	$ 81,068	17-1	1
2	Louise Mermelstein	Dietary Supervisor	Support	0.00	50,000	7	33.34	Salary	25,000	1-7	2
3	Marvin Mermelstein	Plant Supervisor	Support	30.20	142,338	7	37.20	Salary	83,664	6-7	3
4	Doreen Mermelstein	Office Manager	Administrative	0.00	80,069	13	13.33	Salary	40,034	21-7	4
5											5
6	Marvin Mermelstein	Asst. Administrator	Administrative	See Above	213,506	10	37.20	Salary	125,496	17-7	6
7	Joseph Mermelstein	Owner	Administrative	5.20	47,236	4	37.02	Salary	27,764	17-7	7
8	Barry Taerbaum	Administrator	Administrative	25.00	411,498	19	44.03	Salary	175,013	17-7	8
9	Marvin Mermelstein Family Trust		N/A	19.80							9
10	Joseph Mermelstein Family Trust		N/A	19.80							10
11											11
12											12
13								TOTAL	$ 558,039		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 Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Nivram Management, Inc.
Street Address: 6500 N. Hamlin Avenue
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: (847) 679-7484
Fax Number: (847) 679-7494

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	25	Auto Expense	Resident Beds	624	3	$ 432	$	231	$ 160	1
2	20	Advertising	Resident Beds	624	3	855		231	317	2
3	21	Bank Charges	Resident Beds	624	3	93		231	34	3
4	6	Repairs and Maintenance	Resident Beds	624	3	7,644		231	2,830	4
5	5	Utilities	Resident Beds	624	3	17,638		231	6,529	5
6	21	Delivery Expense	Resident Beds	624	3	621		231	230	6
7	21	Contributions	Resident Beds	624	3	285		231	106	7
8	21	Office Expense	Resident Beds	624	3	10,890		231	4,031	8
9	20	Dues & Subscriptions	Resident Beds	624	3	3,211		231	1,189	9
10	21	Taxes Other	Resident Beds	624	3	297		231	110	10
11	32	Interest Expense	Resident Beds	624	3	18		231	7	11
12	22	Payroll Taxes	Resident Beds	624	3	133,666		231	49,482	12
13	26	Insurance Expense	Resident Beds	624	3	3,520		231	1,303	13
14	22	Health Insurance	Resident Beds	624	3	47,658		231	17,643	14
15	7	Scavenger	Resident Beds	624	3	480		231	178	15
16	35	Equipment Rental	Resident Beds	624	3	2,499		231	925	16
17	2	Sales Taxes	Resident Beds	624	3	897		231	332	17
18	21	Postage	Resident Beds	624	3	1,435		231	531	18
19	20	Licenses and Permits	Resident Beds	624	3	339		231	125	19
20	25	Travel Expense	Resident Beds	624	3	5,702		231	2,111	20
21	30	Depreciation	Resident Beds	624	3	5,872		231	2,174	21
22	21	Data Processing	Resident Beds	624	3	2,358		231	873	22
23	21	Telephone	Resident Beds	624	3	7,669		231	2,839	23
24										24
25	TOTALS					$ 254,079	$		$ 94,059	25

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Nivram Management, Inc.
Street Address: 6500 N. Hamlin Avenue
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: (847) 679-7484
Fax Number: (847) 679-7494

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Plant Salary	Direct Cost	1	1	$ 83,664	$ 83,664	1	$ 83,664	1
2	17	Assistant Administrator Salary	Direct Cost	1	1	125,496	125,496	1	125,496	2
3	21	Office Manager Salary	Direct Cost	1	1	40,034	40,034	1	40,034	3
4	1	Food Service Supervisor Salary	Direct Cost	1	1	25,000	25,000	1	25,000	4
5	17	Administrative Salaries	Direct Cost	1	1	108,832	108,832	1	108,832	5
6	17	Administrator Salary	Direct Cost	1	1	300,253	300,253	1	300,253	6
7	21	Maintenance Salary	Direct Cost	1	1	94,515	94,515	1	94,515	7
8	6	Maintenance Salary	Direct Cost	1	1	98,154	98,154	1	98,154	8
9	21	Bank Fees	Resident Beds	624	3	434		231	161	9
10	30	Depreciation Expense	Resident Beds	624	3	22,025		231	8,153	10
11	19	Legal Fees	Resident Beds	624	3	8,298		231	3,072	11
12	33	Real Estate Taxes	Resident Beds	624	3	28,594		231	10,585	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					$ 935,299	$ 875,948		$ 897,919	25

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Deutsche Bank Mortgage, Inc.		X	Mortgage	$134,314.00	2/7/8	$ 13,345,000	$ 0	03/01/2043	6.0800	$ 660,542	1
2	Berkeley Point Capital, L.L.C.		X	Mortgage	$123,479.00	5/22/12	13,345,000	13,245,475	05/22/2047	3.4300	266,017	2
3												3
4												4
5												5
	Working Capital											
6	BM of Chicago Ridge RE, LLC	X		Line of Credit	n/a	n/a	196,810	0	01/31/2012	3.0000	42	6
7												7
8												8
9	TOTAL Facility Related				$257,793.00		$ 26,886,810	$ 13,245,475			$ 926,601	9
	B. Non-Facility Related*											
10	Offset Against Int Inc										(5,091)	10
11	Offset Against Int Inc										(917)	11
12	Citi Credit Card		X	Financing	n/a	n/a	n/a	n/a	n/a	n/a	7	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (6,001)	14
15	TOTALS (line 9+line14)						$ 26,886,810	$ 13,245,475			$ 920,600	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 89,957 Line # 26

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

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

Facility Name & ID Number Chicago Ridge Nursing Center **#** 0045815 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	431,953	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.)	$	476,596	2
3. Under or (over) accrual (line 2 minus line 1).	$	44,643	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)	$	470,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	514,643	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2007	489,900	8
2008	574,384	9
2009	390,040	10
2010	400,687	11
2011	499,259	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2011	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Chicago Ridge Nursing Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0045815

CONTACT PERSON REGARDING THIS REPORT Sanford B. Alper

TELEPHONE (847) 580-4100 FAX #: (847) 580-4199

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

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	24-18-101-025-0000	Nursing Home	$ 128,525.00	$ 128,525.00
2.	24-18-101-039-0000	Nursing Home	$ 337,485.00	$ 337,485.00
3.	10-35-325-029-0000	Management Company	$ 3,819.65	$ 1,216.04
4.	10-35-325-015-0000	Management Company	$ 29,429.38	$ 9,369.30
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 499,259.03	$ 476,595.34

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 87,480 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3 + Basement

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	73,980	7/31/2007	$ 435,000	1
2					2
3	TOTALS	73,980		$ 435,000	3

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	231		2007		$ 9,936,943	$ 255,501	20-40	$ 255,501	$	$ 1,383,961	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sign			2001	1,419	36	39	36		404	9
10	Carpet			2002	2,240	58	39	58		607	10
11	Alarm			2002	22,000	564	39	564		5,758	11
12	Washer & Dryer			2002	29,304	752	39	752		8,173	12
13	Phone System			2002	10,667	273	39	273		2,745	13
14	A/C System			2002	11,200	287	39	287		2,883	14
15	Electrical Improvements			2002	3,000	77	39	77		773	15
16	Light Fixtures			2002	10,192	262	39	262		2,626	16
17	RC Alarm			2003	4,500	115	39	115		1,124	17
18	Water Heater			2003	16,500		5			16,500	18
19	Boiler			2004	21,500	552	39	552		4,412	19
20	Paving Improvements			2005	21,800	1,454	39	1,454		11,144	20
21	Bathroom Improvements			2005	634	16	39	16		120	21
22	Fire Smoke Dampers			2005	3,475	89	39	89		705	22
23	Boiler			2005	11,960	1,145	5	1,145		14,250	23
24	Locks			2006	4,374	112	39	112		682	24
25	Fire Alarm System			2006	98,711	2,531	39	2,531		15,397	25
26	AC Chiller Unit			2006	81,000	2,076	39	2,076		14,190	26
27	Furnance			2007	13,500	346	39	346		2,048	27
28	Temp Reset Control for Boiler			2007	2,750	70	39	70		410	28
29	Faucets			2007	2,298	59	39	59		344	29
30	Electrical Disconnect for Chiller Unit			2007	8,000	205	39	205		1,196	30
31	Add'l Amount for '06 AC Chiller Unit			2007	8,000	205	39	205		1,179	31
32	Hot Water Storage Tank			2007	22,000	564	39	564		3,149	32
33	Control System for New Chiller			2007	1,191	31	39	31		174	33
34	Grab Bars			2007	4,941	127	39	127		708	34
35	Boiler Room Change-Over Valves			2007	8,380	215	39	215		1,182	35
36	Water Coller, attached to Bld			2007	1,087	28	39	28		163	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 Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Carpeting	2007	$ 3,138	$ 80	39	$ 80	$	$ 408	37
38	Exhaust Fans	2009	7,098	182	39	182		637	38
39	Sprinkler System	2010	239,314	1,994	40	1,994		5,982	39
40	Boiler	2010	47,900	319	40	319		957	40
41	Electrical Breakers	2010	7,000	58	40	58		174	41
42	Fire Alarm	2010	8,982	150	40	150		450	42
43	Therapy Room - Flooring, Cabinets, Countertops	2011	2,635	67	39	67		101	43
44	Water Heater	2011	8,170	817	10	817		1,634	44
45	Sprinkler System	2011	4,000	100	40	100		108	45
46	Sprinkler System	2012	6,370	136	40	136		271	46
47	Laminate Flooring	2012	4,768	102	39	102		102	47
48	Stairway Exit Doors	2012	9,097	58	39	58		58	48
49									49
50									50
51									51
52									52
53									53
54									54
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56									56
57									57
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59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 10,712,038	$ 271,813		$ 271,813	$	$ 1,507,889	70

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	$ 74,268	$ 15,669	$ 15,669	$	5	$ 73,796	71
72	Current Year Purchases	29,418	5,030	5,030		5	5,030	72
73	Fully Depreciated Assets	62,113					62,113	73
74	Management & Real Estate Co.	1,764,084	186,766	186,766		10	968,854	74
75	TOTALS	$ 1,929,883	$ 207,465	$ 207,465	$		$ 1,109,793	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)	$ 13,076,921	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 479,278	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 479,278	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,617,682	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2013	$
13.	/2014	$
14.	/2015	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 3,348 Description: Copier - $2,423; Management Company - Copier - $925
(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.

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			391,054			391,054	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				200,617		200,617	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Attached Schedule						23,276		23,276	12
13	Other (specify):									13
14	TOTAL			$		$ 391,054	$ 223,893		$ 614,947	14

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

STATE OF ILLINOIS

Facility Name & ID Number Chicago Ridge Nursing Center **#** 0045815 **Report Period Beginning:** 01/01/2012 **Ending:** 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2012 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 358,906	$ 472,437	1
2	Cash-Patient Deposits	65,741	65,741	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,742,056	3,742,056	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,579	106,905	6
7	Other Prepaid Expenses	4,749	4,749	7
8	Accounts Receivable (owners or related parties)	1,230	1,230	8
9	Other(specify): Attached Schedule		571,130	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,201,261	$ 4,964,248	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		435,000	13
14	Buildings, at Historical Cost		9,936,943	14
15	Leasehold Improvements, at Historical Cost	395,595	717,331	15
16	Equipment, at Historical Cost	223,564	1,987,648	16
17	Accumulated Depreciation (book methods)	(228,198)	(2,587,293)	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): Deferred Loan Fees		122,413	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 390,961	$ 10,612,042	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,592,222	$ 15,576,290	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 812,796	$ 830,535	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	56,202	56,202	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	70,467	70,467	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		470,000	32
33	Accrued Interest Payable		37,860	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Attached Schedule	3,944,513	3,966,624	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,883,978	$ 5,431,688	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		13,245,475	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)**	$	$ 13,245,475	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,883,978	$ 18,677,163	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (291,756)	$ (3,100,873)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,592,222	$ 15,576,290	48

***(See instructions.)**

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,418,750)	1
2	Restatements (describe):		2
3	Rounding	3	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,418,747)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,476,991	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	(2,350,000)	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)**	$ 1,126,991	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)**	$ (291,756)	24 *

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,516,196	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,516,196	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***	5,091	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,091	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Attached Schedule	230,192	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 230,192	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,751,479	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,402,184	31
32	Health Care	2,756,940	32
33	General Administration	1,681,136	33
	B. Capital Expense		
34	Ownership	1,890,844	34
	C. Ancillary Expense		
35	Special Cost Centers	1,543,384	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,274,488	40
41	**Income before Income Taxes (line 30 minus line 40)****	3,476,991	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 3,476,991	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

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

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,135	2,619	$ 86,983	$ 33.21	1
2	Assistant Director of Nursing					2
3	Registered Nurses	28,761	29,881	756,923	25.33	3
4	Licensed Practical Nurses	13,021	13,257	269,087	20.30	4
5	CNAs & Orderlies	73,201	77,186	727,629	9.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	32,399	15.58	9
10	Activity Assistants	7,709	8,240	75,315	9.14	10
11	Social Service Workers	11,994	13,121	245,755	18.73	11
12	Dietician					12
13	Food Service Supervisor	4,199	4,584	53,013	11.56	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,248	25,800	260,856	10.11	15
16	Dishwashers					16
17	Maintenance Workers	2,100	2,692	29,741	11.05	17
18	Housekeepers	27,170	29,371	274,695	9.35	18
19	Laundry	10,246	11,110	101,568	9.14	19
20	Administrator					20
21	Assistant Administrator	2,080	2,080	58,096	27.93	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,704	3,871	37,157	9.60	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	2,091	2,193	21,328	9.73	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	213,739	228,085	$ 3,030,545 *	$ 13.29	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 9,998	1-3	35
36	Medical Director	O			36
37	Medical Records Consultant	N	2,164	10-3	37
38	Nurse Consultant	T			38
39	Pharmacist Consultant	H			39
40	Physical Therapy Consultant	L			40
41	Occupational Therapy Consultant	Y			41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	F			43
44	Activity Consultant	E			44
45	Social Service Consultant	E	6,251	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 18,413		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	14,500	$ 369,762	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	14,500	$ 369,762		53

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Darlene Guzy	Assistant Admin	0.00	$ 58,096
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 58,096

B. Administrative - Other

Description	Amount
Management Fees	$ 1,003,324
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,003,324
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
See Attached Schedule		76,374
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 76,374

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 62,226
Unemployment Compensation Insurance	58,828
FICA Taxes	239,152
Employee Health Insurance	30,667
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Dental Insurance	1,462
Allocation from Management Company	67,125
Employees' Physical Exams	1,160
TOTAL (agree to Schedule V, line 22, col.8)	$ 460,620

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	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 60)	
Patient Background Checks	600
Yellow Pages Advertising	48
See Attached Schedule	6,542
Allocation from Management Company	1,631
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(48)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,773

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,485
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,485

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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? **No**
If YES, give association name and amount. **N/A**

(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? **5-10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **N/A**

(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. $ **928,437**
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? **Yes** If YES, attach an explanation of the allocation.

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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