FOR BHF USE

LL1

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

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0045815

Facility Name: Chicago Ridge Nursing Center

Address: 10602 Southwest Hwy (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 01/01/2013 to 12/31/2013 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, Director
(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: 01/01/2013 Ending: 12/31/2013

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	84,315	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	84,315	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	68,052	3,130	8,513	79,695	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	68,052	3,130	8,513	79,695	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.52%

D. How many bed-hold days during this year were paid by the Department?
0 (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 4,903

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

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	335,649	20,564	9,645	365,858		365,858	27,071	392,929			1
2	Food Purchase		382,194		382,194		382,194	(585)	381,609			2
3	Housekeeping	287,106	42,549		329,655		329,655		329,655			3
4	Laundry	99,239	9,593		108,832		108,832		108,832			4
5	Heat and Other Utilities			192,562	192,562		192,562	5,819	198,381			5
6	Maintenance	33,212	50,987		84,199		84,199	172,713	256,912			6
7	Other (specify):* Attached Schedule			30,089	30,089		30,089	178	30,267			7
8	**TOTAL General Services**	755,206	505,887	232,296	1,493,389		1,493,389	205,196	1,698,585			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,019,700	255,681	241,574	2,516,955		2,516,955		2,516,955			10
10a	Therapy											10a
11	Activities	108,102	2,814		110,916		110,916		110,916			11
12	Social Services	225,440	106,057	4,730	336,227		336,227		336,227			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,353,242	364,552	246,304	2,964,098		2,964,098		2,964,098			16
	C. General Administration											
17	Administrative	57,288		860,039	917,327		917,327	(404,409)	512,918			17
18	Directors Fees											18
19	Professional Services			141,129	141,129		141,129	29,243	170,372			19
20	Dues, Fees, Subscriptions & Promotions			10,690	10,690		10,690	3,550	14,240			20
21	Clerical & General Office Expenses	34,768		73,073	107,841		107,841	46,717	154,558			21
22	Employee Benefits & Payroll Taxes			387,388	387,388		387,388	68,981	456,369			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,485	2,485		2,485		2,485			24
25	Other Admin. Staff Transportation			281	281		281	265	546			25
26	Insurance-Prop.Liab.Malpractice			6,101	6,101		6,101	261,841	267,942			26
27	Other (specify):*											27
28	**TOTAL General Administration**	92,056		1,481,186	1,573,242		1,573,242	6,188	1,579,430			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,200,504	870,439	1,959,786	6,030,729		6,030,729	211,384	6,242,113			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: 01/01/2013 Ending: 12/31/2013

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			26,767	26,767		26,767	453,851	480,618			30
31	Amortization of Pre-Op. & Org.							3,565	3,565			31
32	Interest			293	293		293	333,785	334,078			32
33	Real Estate Taxes							557,753	557,753			33
34	Rent-Facility & Grounds			1,860,000	1,860,000		1,860,000	(1,860,000)				34
35	Rent-Equipment & Vehicles			2,241	2,241		2,241	22	2,263			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,889,301	1,889,301		1,889,301	(511,024)	1,378,277			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		828	422,070	422,898		422,898		422,898			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			579,870	579,870		579,870		579,870			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		828	1,001,940	1,002,768		1,002,768		1,002,768			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,200,504	871,267	4,851,027	8,922,798		8,922,798	(299,640)	8,623,158			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: 01/01/2013 Ending: 12/31/2013

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	(585)	2		13
14	Non-Care Related Interest	(116,197)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,250)	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	(50,463)	21		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				28
29	Other-Attach Schedule	(281)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (168,776)		$	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	(130,864)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (130,864)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (299,640)		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: 01/01/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Contributions (Management Company)	$ (4)	21	1
2	Sales Tax (Management Company)	(277)	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**	(281)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	27,071	0	0	0	0	0	0	0	0	27,071	1
2	Food Purchase	(862)	0	277	0	0	0	0	0	0	0	0	(585)	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	5,819	0	0	0	0	0	0	0	0	0	5,819	5
6	Maintenance	0	1,636	171,077	0	0	0	0	0	0	0	0	172,713	6
7	Other (specify):*	0	178	0	0	0	0	0	0	0	0	0	178	7
8	**TOTAL General Services**	(862)	7,633	198,425	0	0	0	0	0	0	0	0	205,196	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	(404,409)	0	0	0	0	0	0	0	0	(404,409)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	4,648	24,595	0	0	0	0	0	0	0	29,243	19
20	Fees, Subscriptions & Promotions	0	3,280	270	0	0	0	0	0	0	0	0	3,550	20
21	Clerical & General Office Expenses	(51,717)	4,501	94,617	(684)	0	0	0	0	0	0	0	46,717	21
22	Employee Benefits & Payroll Taxes	0	68,981	0	0	0	0	0	0	0	0	0	68,981	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	0	47	218	0	0	0	0	0	0	0	0	265	25
26	Insurance-Prop.Liab.Malpractice	0	1,585	0	260,256	0	0	0	0	0	0	0	261,841	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(51,717)	78,394	(304,656)	284,167	0	0	0	0	0	0	0	6,188	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(52,579)	86,027	(106,231)	284,167	0	0	0	0	0	0	0	211,384	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Chicago Ridge Nursing Center **#** 0045815 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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	9,421	444,430	0	0	0	0	0	0	0	453,851	30
31	Amortization of Pre-Op. & Org.	0	0	0	3,565	0	0	0	0	0	0	0	3,565	31
32	Interest	(116,197)	7	0	449,975	0	0	0	0	0	0	0	333,785	32
33	Real Estate Taxes	0	0	11,181	546,572	0	0	0	0	0	0	0	557,753	33
34	Rent-Facility & Grounds	0	22,212	(1,882,212)	0	0	0	0	0	0	0	0	(1,860,000)	34
35	Rent-Equipment & Vehicles	0	0	22	0	0	0	0	0	0	0	0	22	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(116,197)	22,219	(1,861,588)	1,444,542	0	0	0	0	0	0	0	(511,024)	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)**	(168,776)	108,246	(1,967,819)	1,728,709	0	0	0	0	0	0	0	(299,640)	45

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	Chicago	Nivram Mngt, 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 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%	$ 47	$ 47	1
2	V	6	Repairs & Maintenance		Nivram Management, Inc.	50.00%	1,636	1,636	2
3	V	5	Utilities		Nivram Management, Inc.	50.00%	5,819	5,819	3
4	V	21	Contributions		Nivram Management, Inc.	50.00%	4	4	4
5	V	21	Office Expense		Nivram Management, Inc.	50.00%	4,450	4,450	5
6	V	20	Dues & Subscriptions		Nivram Management, Inc.	50.00%	3,280	3,280	6
7	V	21	Taxes - Other		Nivram Management, Inc.	50.00%	47	47	7
8	V	32	Interest Expense		Nivram Management, Inc.	50.00%	7	7	8
9	V	22	Payroll Taxes		Nivram Management, Inc.	50.00%	51,314	51,314	9
10	V	34	Rent		Nivram Management, Inc.	50.00%	22,212	22,212	10
11	V	26	Insurance		Nivram Management, Inc.	50.00%	1,585	1,585	11
12	V	22	Health Insurance		Nivram Management, Inc.	50.00%	17,667	17,667	12
13	V	7	Scavenger		Nivram Management, Inc.	50.00%	178	178	13
14	Total			$			$ 108,246	$ * 108,246	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: 01/01/2013 Ending: 12/31/2013

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	35	Rental Equipment	$	Nivram Management, Inc.	50.00%	$ 22	$ 22	15
16	V	2	Sales Taxes		Nivram Management, Inc.	50.00%	277	277	16
17	V	21	Postage		Nivram Management, Inc.	50.00%	756	756	17
18	V	19	Legal & Accounting		Nivram Management, Inc.	50.00%	1,448	1,448	18
19	V	20	Licenses & Permits		Nivram Management, Inc.	50.00%	270	270	19
20	V	25	Travel		Nivram Management, Inc.	50.00%	218	218	20
21	V	30	Depreciation		Nivram Management, Inc.	50.00%	1,267	1,267	21
22	V	21	Data Processing		Nivram Management, Inc.	50.00%	1,068	1,068	22
23	V	21	Telephone		Nivram Management, Inc.	50.00%	2,323	2,323	23
24	V	17	Management Fees	860,039	Nivram Management, Inc.	50.00%		(860,039)	24
25	V	6	Plant Salary		Nivram Management, Inc.		71,077	71,077	25
26	V	17	Office Manager Salary		Nivram Management, Inc.		40,756	40,756	26
27	V	1	Food Service Supervisor Salary		Nivram Management, Inc.		27,071	27,071	27
28	V	17	Administrative Salaries		Nivram Management, Inc.		111,097	111,097	28
29	V	17	Administrator Salary		Nivram Management, Inc.		197,159	197,159	29
30	V	21	Clerical Salaries		Nivram Management, Inc.		90,367	90,367	30
31	V	6	Maintenance Salary		Nivram Management, Inc.		100,000	100,000	31
32	V	17	Assistant Administrator		Nivram Management, Inc.		106,618	106,618	32
33	V	34	Rental Income	22,212	Hamlin & Arthur Partnership			(22,212)	33
34	V	21	Bank Charges		Hamlin & Arthur Partnership		103	103	34
35	V	30	Depreciation		Hamlin & Arthur Partnership		8,154	8,154	35
36	V	19	Legal Fees		Hamlin & Arthur Partnership		3,200	3,200	36
37	V	33	Real Estate Taxes		Hamlin & Arthur Partnership		11,181	11,181	37
38	V	34	Rental Income	1,860,000	BM of Chicago Ridge Real Estate, LLC			(1,860,000)	38
39	Total			$ 2,742,251			$ 774,432	$ * (1,967,819)	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: 01/01/2013 Ending: 12/31/2013

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	32	Interest Income	$ 570	BM of Chicago Ridge Real Estate, LLC		$	$ (570)	15
16	V	21	Bank Charges		BM of Chicago Ridge Real Estate, LLC		5	5	16
17	V	19	Accounting Fees		BM of Chicago Ridge Real Estate, LLC		24,595	24,595	17
18	V	33	Real Estate Tax Expense		BM of Chicago Ridge Real Estate, LLC		546,572	546,572	18
19	V	26	Insurance Expense		BM of Chicago Ridge Real Estate, LLC		260,256	260,256	19
20	V	21	Other Taxes		BM of Chicago Ridge Real Estate, LLC		500	500	20
21	V	32	Interest Expense		BM of Chicago Ridge Real Estate, LLC		450,545	450,545	21
22	V	30	Depreciation Expense		BM of Chicago Ridge Real Estate, LLC		444,430	444,430	22
23	V	31	Amortization Expense		BM of Chicago Ridge Real Estate, LLC		3,565	3,565	23
24	V	21	Income Tax Benefit	1,189	BM of Chicago Ridge Real Estate, LLC			(1,189)	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			$ 1,759			$ 1,730,468	$ * 1,728,709	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: 01/01/2013 Ending: 12/31/2013

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: 01/01/2013 Ending: 12/31/2013

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 Mermelsein	Administrator	Administrative	0.00	166,667	13	33.33	Salary	$ 83,333	17-1	1
2	Louise Mermelstein	Dietary Supervisor	Support	0.00	54,142	7	33.34	Salary	27,071	1-7	2
3	Marvin Mermelstein	Plant Supervisor	Support	30.20	120,925	7	37.20	Salary	71,077	6-7	3
4	Doreen Mermelstein	Office Manager	Administrative	0.00	81,512	13	13.33	Salary	40,756	21-7	4
5											5
6	Marvin Mermelstein	Asst. Administrator	Administrative	See Above	181,387	10	37.20	Salary	106,617	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	230,747	19	44.03	Salary	67,063	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	$ 423,681		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: 01/01/2013 Ending: 2/31/2013

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	$ 126	$	231	$ 47	1
2	6	Repairs & Maintenance	Resident Beds	624	3	4,422		231	1,637	2
3	5	Utilities	Resident Beds	624	3	15,718		231	5,819	3
4	21	Contributions	Resident Beds	624	3	10		231	4	4
5	21	Office Expense	Resident Beds	624	3	12,020		231	4,450	5
6	20	Dues & Subscriptions	Resident Beds	624	3	8,861		231	3,280	6
7	21	Taxes Other	Resident Beds	624	3	128		231	47	7
8	32	Interest Expense	Resident Beds	624	3	19		231	7	8
9	22	Payroll Taxes	Resident Beds	624	3	138,615		231	51,314	9
10	34	Rent	Resident Beds	624	3	60,000		231	22,212	10
11	26	Insurance	Resident Beds	624	3	4,282		231	1,585	11
12	22	Health Insurance	Resident Beds	624	3	47,724		231	17,667	12
13	7	Scavenger	Resident Beds	624	3	480		231	178	13
14	35	Rental Equipment	Resident Beds	624	3	60		231	22	14
15	2	Sales Taxes	Resident Beds	624	3	749		231	277	15
16	21	Postage	Resident Beds	624	3	2,042		231	756	16
17	19	Legal & Accounting	Resident Beds	624	3	3,911		231	1,448	17
18	20	Licenses & Permits	Resident Beds	624	3	729		231	270	18
19	25	Travel	Resident Beds	624	3	590		231	218	19
20	30	Depreciation	Resident Beds	624	3	3,422		231	1,267	20
21	21	Data Processing	Resident Beds	624	3	2,884		231	1,068	21
22	21	Telephone	Resident Beds	624	3	6,274		231	2,323	22
23	6	Plant Salary	Direct Cost	1	1	71,077	71,077	1	71,077	23
24	17	Assistant Administrator Salary	Direct Cost	1	1	106,617	106,617	1	106,617	24
25	TOTALS					$ 490,760	$ 177,694		$ 293,590	25

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2013 Ending: 2/31/2013

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	21	Office Manager Salary	Direct Cost	1	1	$ 40,756	$ 40,756	1	$ 40,756	1
2	1	Food Service Supervisor Salary	Direct Cost	1	1	27,071	27,071	1	27,071	2
3	17	Administrative Salaries	Direct Cost	1	1	111,097	111,097	1	111,097	3
4	17	Administrator Salary	Direct Cost	1	1	67,063	67,063	1	67,063	4
5	21	Clerical Salaries	Direct Cost	1	1	220,464	220,464	1	220,464	5
6	6	Maintenace Salary	Direct Cost	1	1	100,000	100,000	1	100,000	6
7	21	Bank Fees	Resident Beds	624	3	280		231	104	7
8	30	Depreciation	Resident Beds	624	3	22,025		231	8,153	8
9	19	Legal Fees	Resident Beds	624	3	8,643		231	3,200	9
10	33	Real Estate Taxes	Resident Beds	624	3	30,203		231	11,181	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					$ 627,602	$ 566,451		$ 589,089	25

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	Bberkeley Point Capital L.L.C.		X	Mortgage	$123,479.00	5/22/12	$ 13,345,000	$ 13,041,239	5/22/2047	3.4300	$ 449,975	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$123,479.00		$ 13,345,000	$ 13,041,239			$ 449,975	9
	B. Non-Facility Related*											
10	Offset Against Int Inc										(570)	10
11	Offset Against Int Inc										(115,627)	11
12	Credit Card		X	Financing	n/a	n/a	n/a	n/a	n/a	n/a	7	12
13	Credit Card		X	Financing	n/a	n/a	n/a	n/a	n/a	n/a	293	13
14	TOTAL Non-Facility Related						$	$			$ (115,897)	14
15	TOTALS (line 9+line14)						$ 13,345,000	$ 13,041,239			$ 334,078	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 54,370 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:** 01/01/2013 **Ending:** 12/31/2013

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 470,000	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.)		$ 505,375	2
3. Under or (over) accrual (line 2 minus line 1).		$ 35,375	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 522,378	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.		$ 557,753	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	574,384	8
	2009	390,040	9
	2010	400,687	10
	2011	499,259	11
	2012	529,314	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 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 2012 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	24-18-101-025-0000	Nursing Home	$ 357,895.91	$ 357,895.91
2.	24-18-101-039-0000	Nursing Home	$ 136,298.18	$ 136,298.18
3.	10-35-325-029-0000	Management Company	$ 4,022.75	$ 1,281.00
4.	10-35-325-015-0000	Management Company	$ 31,097.53	$ 9,900.00
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 529,314.37	$ 505,375.09

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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).

N/A

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		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: 01/01/2013 Ending: 12/31/2013

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	$	$ 1,639,462	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sign			2001	1,419	36	39	36		440	9
10	Carpet			2002	2,240	58	39	58		665	10
11	Alarm			2002	22,000	564	39	564		6,322	11
12	Washer & Dryer			2002	29,304	752	39	752		8,925	12
13	Phone System			2002	10,667	273	39	273		3,018	13
14	A/C System			2002	11,200	287	39	287		3,170	14
15	Electrical Improvements			2002	3,000	77	39	77		850	15
16	Light Fixtures			2002	10,192	262	39	262		2,888	16
17	RC Alarm			2003	4,500	115	39	115		1,239	17
18	Water Heater			2003	16,500		5			16,500	18
19	Boiler			2004	21,500	552	39	552		4,964	19
20	Paving Improvements			2005	21,800	1,454	39	1,454		12,598	20
21	Bathroom Improvements			2005	634	16	39	16		136	21
22	Fire Smoke Dampers			2005	3,475	89	39	89		794	22
23	Boiler			2005	11,960		5			11,960	23
24	Locks			2006	4,374	112	39	112		794	24
25	Fire Alarm System			2006	98,711	2,531	39	2,531		17,928	25
26	AC Chiller Unit			2006	81,000	2,076	39	2,076		16,266	26
27	Furnance			2007	13,500	346	39	346		2,394	27
28	Temp Reset Control for Boiler			2007	2,750	70	39	70		480	28
29	Faucets			2007	2,298	59	39	59		403	29
30	Electrical Disconnect for Chiller Unit			2007	8,000	205	39	205		1,401	30
31	Add'l Amount for '06 AC Chiller Unit			2007	8,000	205	39	205		1,384	31
32	Hot Water Storage Tank			2007	22,000	564	39	564		3,713	32
33	Control System for New Chiller			2007	1,191	31	39	31		205	33
34	Grab Bars			2007	4,941	127	39	127		835	34
35	Boiler Room Change-Over Valves			2007	8,380	215	39	215		1,397	35
36	Water Cooler, attached to Building			2007	1,087	28	39	28		191	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: 01/01/2013 Ending: 12/31/2013

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	$	$ 488	37
38	Exhaust Fans	2009	7,098	182	39	182		819	38
39	Sprinkler System	2010	239,314	1,994	40	1,994		7,976	39
40	Boiler	2010	47,900	319	40	319		1,276	40
41	Electrical Breakers	2010	7,000	58	40	58		232	41
42	Fire Alarm	2011	8,982	150	40	150		600	42
43	Therapy Room - Flooring, Cabinets, Countertops	2011	2,635	67	39	67		168	43
44	Water Heater	2011	8,170	817	10	817		2,451	44
45	Sprinkler System	2011	4,000	100	40	100		208	45
46	Sprinkler System	2012	6,370	159	40	159		407	46
47	Laminate Flooring	2012	4,768	122	39	122		204	47
48	Stairway Exit Doors	2012	9,097	234	39	234		116	48
49	Water Pump	2013	2,625	57	39	57		57	49
50	Power Conditioner	2013	5,600	105	40	105		105	50
51	Elevator	2013	147,995	2,467	40	2,467		2,467	51
52	Roof Replacement	2013	152,325	1,269	40	1,269		1,269	52
53	Parking Lot Repayment	2013	7,100	44	40	44		44	53
54	Smoking Shelter	2013	4,053	17	40	17		17	54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 11,031,736	$ 274,846		$ 274,846	$	$ 1,780,226	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: 01/01/2013 Ending: 12/31/2013

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	$ 103,686	$ 19,979	$ 19,979	$	5	$ 93,775	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	62,113					62,113	73
74	Management & Real Estate Co.	1,764,084	185,793	185,793				74
75	TOTALS	$ 1,929,883	$ 205,772	$ 205,772	$		$ 155,888	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)	$ 13,396,619	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 480,618	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 480,618	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)	$ 1,936,114	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: 01/01/2013 Ending: 12/31/2013

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: BM of Chicago Ridge Real Estate, L.L.C.
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 09/01/2008
Ending 12/31/2043

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

	Fiscal Year Ending	Annual Rent
12.	12/31/2014	$ 1,860,000
13.	12/31//2015	$ 1,860,000
14.	12/31//2016	$ 1,860,000

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: $ 2,263 Description: Copier - $2,241 ; Management Company - Copier - $22
(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: 01/01/2013 Ending: 12/31/2013

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: 01/01/2013 Ending: 12/31/2013

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			422,070			422,070	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Rentals	39-2					828		828	12
13	Other (specify):									13
14	TOTAL			$		$ 422,070	$ 828		$ 422,898	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.

Facility Name & ID Number Chicago Ridge Nursing Center **#** 0045815 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013 **(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	$ 413,053	$ 691,897	1
2	Cash-Patient Deposits	106,477	106,477	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,081,822	2,081,822	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,454	148,063	6
7	Other Prepaid Expenses	33,752	33,752	7
8	Accounts Receivable (owners or related parties)	79,877	79,877	8
9	Other(specify): Attached Schedule		466,388	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,742,435	$ 3,608,276	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	398,220	1,037,029	15
16	Equipment, at Historical Cost	223,564	1,987,648	16
17	Accumulated Depreciation (book methods)	(254,965)	(3,058,490)	17
18	Deferred Charges		118,847	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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 366,819	$ 10,456,977	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,109,254	$ 14,065,253	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 569,786	$ 581,477	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	77,516	77,516	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	85,502	85,502	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		522,378	32
33	Accrued Interest Payable		37,277	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	482	482	35
	Other Current Liabilities(specify):			
36	Attached Schedule	4,192,481	4,213,721	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,925,767	$ 5,518,353	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		13,041,239	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)**	$	$ 13,041,239	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,925,767	$ 18,559,592	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,816,513)	$ (4,494,339)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,109,254	$ 14,065,253	48

***(See instructions.)**

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (291,756)	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)**	$ (291,759)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,075,246	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	(4,600,000)	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)**	$ (1,524,754)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,816,513)	24 *

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$ 11,691,196	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,691,196	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***	115,627	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 115,627	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Attached Schedule	191,703	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 191,703	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,998,526	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,493,389	31
32	Health Care	2,964,098	32
33	General Administration	1,573,242	33
	B. Capital Expense		
34	Ownership	1,889,301	34
	C. Ancillary Expense		
35	Special Cost Centers	422,898	35
36	Provider Participation Fee	579,870	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,922,798	40
41	**Income before Income Taxes (line 30 minus line 40)****	3,075,728	41
42	**Income Taxes**	(482)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 3,075,246	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: 01/01/2013 Ending: 12/31/2013

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	2,346	2,490	$ 83,784	$ 33.65	1
2	Assistant Director of Nursing					2
3	Registered Nurses	31,659	32,278	862,499	26.72	3
4	Licensed Practical Nurses	17,027	17,074	354,627	20.77	4
5	CNAs & Orderlies	65,549	68,725	697,776	10.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	31,358	15.08	9
10	Activity Assistants	7,437	8,013	76,744	9.58	10
11	Social Service Workers	11,162	11,664	225,440	19.33	11
12	Dietician					12
13	Food Service Supervisor	4,181	4,373	52,485	12.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,957	26,365	283,164	10.74	15
16	Dishwashers					16
17	Maintenance Workers	2,883	3,019	33,212	11.00	17
18	Housekeepers	26,396	28,388	287,106	10.11	18
19	Laundry	9,326	10,138	99,239	9.79	19
20	Administrator					20
21	Assistant Administrator	2,080	2,080	57,288	27.54	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,317	3,432	34,768	10.13	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					31
32	Other Health C: Medical Records	1,982	2,076	21,014	10.12	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	211,382	222,195	$ 3,200,504 *	$ 14.40	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	$ 9,645	1-3	35
36	Medical Director	O			36
37	Medical Records Consultant	N	1,392	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	4,730	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 15,767		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	9,029	$ 240,182	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	9,029	$ 240,182		53

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Darlene Guzy	Assistant Admin	0.00	$ 57,288
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 57,288

B. Administrative - Other

Description	Amount
Management Fees	$ 860,039
TOTAL (agree to Schedule V, line 17, col. 3)	$ 860,039
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
See Attached Schedule		141,129
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 141,129

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 58,808
Unemployment Compensation Insurance	56,053
FICA Taxes	242,943
Employee Health Insurance	28,456
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Dental Insurance	1,128
Allocation from Management Company	68,981
TOTAL (agree to Schedule V, line 22, col.8)	$ 456,369

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 155)	
Patient Background Checks	1,550
Attached Schedule	9,140
Allocation from Management Company	3,550
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,240

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,485
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,485

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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: 01/01/2013 Ending: 12/31/2013

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 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. $ **579,870**
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