FOR BHF USE

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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 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:

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 01/01/2014 to 12/31/2014 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, Sute 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: 01/01/2014 Ending: 12/31/2014

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	69,373	2,215	7,132	78,720	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	69,373	2,215	7,132	78,720	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.36%

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 4,573

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: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	330,363	24,943	9,927	365,233		365,233	25,266	390,499			1
2	Food Purchase		405,264		405,264		405,264	(460)	404,804			2
3	Housekeeping	288,574	36,802		325,376		325,376		325,376			3
4	Laundry	106,092	9,000		115,092		115,092		115,092			4
5	Heat and Other Utilities			241,373	241,373		241,373	6,519	247,892			5
6	Maintenance	47,961	51,324		99,285		99,285	253,147	352,432			6
7	Other (specify):* Attached Schedule			29,618	29,618		29,618	730	30,348			7
8	TOTAL General Services	772,990	527,333	280,918	1,581,241		1,581,241	285,202	1,866,443			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,962,140	258,470	273,074	2,493,684		2,493,684		2,493,684			10
10a	Therapy	288			288		288		288			10a
11	Activities	109,746	978		110,724		110,724		110,724			11
12	Social Services	167,213	134,581	3,357	305,151		305,151		305,151			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,239,387	394,029	276,431	2,909,847		2,909,847		2,909,847			16
	C. General Administration											
17	Administrative	58,789		1,147,255	1,206,044		1,206,044	(537,802)	668,242			17
18	Directors Fees											18
19	Professional Services			87,918	87,918		87,918	10,843	98,761			19
20	Dues, Fees, Subscriptions & Promotions			12,599	12,599		12,599	2,619	15,218			20
21	Clerical & General Office Expenses	35,209		161,116	196,325		196,325	11,610	207,935			21
22	Employee Benefits & Payroll Taxes			383,483	383,483		383,483	82,176	465,659			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,320	1,320		1,320		1,320			24
25	Other Admin. Staff Transportation			1,114	1,114		1,114	720	1,834			25
26	Insurance-Prop.Liab.Malpractice			5,601	5,601		5,601	305,312	310,913			26
27	Other (specify):*											27
28	TOTAL General Administration	93,998		1,800,406	1,894,404		1,894,404	(124,522)	1,769,882			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,106,375	921,362	2,357,755	6,385,492		6,385,492	160,680	6,546,172			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: 01/01/2014 Ending: 12/31/2014

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			83,258	83,258		83,258	465,514	548,772			30
31	Amortization of Pre-Op. & Org.							3,565	3,565			31
32	Interest			35	35		35	442,950	442,985			32
33	Real Estate Taxes							556,532	556,532			33
34	Rent-Facility & Grounds			1,860,000	1,860,000		1,860,000	(1,860,000)				34
35	Rent-Equipment & Vehicles			2,005	2,005		2,005	93	2,098			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,945,298	1,945,298		1,945,298	(391,346)	1,553,952			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		2,989	417,065	420,054		420,054		420,054			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			575,640	575,640		575,640		575,640			42
43	Other (specify):*							194,232	194,232			43
44	**TOTAL Special Cost Centers**		2,989	992,705	995,694		995,694	194,232	1,189,926			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,106,375	924,351	5,295,758	9,326,484		9,326,484	(36,434)	9,290,050			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: 01/01/2014 Ending: 12/31/2014

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	(460)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(750)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(430)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(124,483)	21		24
25	Fund Raising, Advertising and Promotional	(447)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Attached Schedule	(2,028)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (128,598)		$	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	92,164		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 92,164		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (36,434)		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: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sales Taxes (Management Company)	$ (2,028)	2	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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**	(2,028)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Chicago Ridge Nursing Center **#** 0045815 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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	25,266	0	0	0	0	0	0	0	0	25,266	1
2	Food Purchase	(2,488)	0	2,028	0	0	0	0	0	0	0	0	(460)	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	6,519	0	0	0	0	0	0	0	0	0	6,519	5
6	Maintenance	0	911	252,236	0	0	0	0	0	0	0	0	253,147	6
7	Other (specify):*	0	730	0	0	0	0	0	0	0	0	0	730	7
8	**TOTAL General Services**	(2,488)	8,160	279,530	0	0	0	0	0	0	0	0	285,202	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	(537,802)	0	0	0	0	0	0	0	0	(537,802)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(430)	0	301	10,972	0	0	0	0	0	0	0	10,843	19
20	Fees, Subscriptions & Promotions	(447)	2,898	168	0	0	0	0	0	0	0	0	2,619	20
21	Clerical & General Office Expenses	(125,233)	4,711	133,191	(1,059)	0	0	0	0	0	0	0	11,610	21
22	Employee Benefits & Payroll Taxes	0	81,631	545	0	0	0	0	0	0	0	0	82,176	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	669	51	0	0	0	0	0	0	0	0	720	25
26	Insurance-Prop.Liab.Malpractice	0	2,255	0	303,057	0	0	0	0	0	0	0	305,312	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(126,110)	92,164	(403,546)	312,970	0	0	0	0	0	0	0	(124,522)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(128,598)	100,324	(124,016)	312,970	0	0	0	0	0	0	0	160,680	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Chicago Ridge Nursing Center **#** 0045815 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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	16,884	448,630	0	0	0	0	0	0	0	465,514	30
31	Amortization of Pre-Op. & Org.	0	0	0	3,565	0	0	0	0	0	0	0	3,565	31
32	Interest	0	0	(4)	442,954	0	0	0	0	0	0	0	442,950	32
33	Real Estate Taxes	0	0	14,072	542,460	0	0	0	0	0	0	0	556,532	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	93	0	0	0	0	0	0	0	0	0	93	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	22,305	(1,851,260)	1,437,609	0	0	0	0	0	0	0	(391,346)	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	194,232	0	0	0	0	0	0	0	194,232	43
44	**TOTAL Special Cost Centers**	0	0	0	194,232	0	0	0	0	0	0	0	194,232	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(128,598)	122,629	(1,975,276)	1,944,811	0	0	0	0	0	0	0	(36,434)	45

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 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.	100.00%	$ 669	$ 669	1
2	V	6	Repairs & Maintenance		Nivram Management, Inc.	100.00%	911	911	2
3	V	5	Utilities		Nivram Management, Inc.	100.00%	6,519	6,519	3
4	V	21	Office Expense		Nivram Management, Inc.	100.00%	4,664	4,664	4
5	V	20	Dues & Subscriptions		Nivram Management, Inc.	100.00%	2,823	2,823	5
6	V	21	Taxes - Other		Nivram Management, Inc.	100.00%	47	47	6
7	V	22	Payroll Taxes		Nivram Management, Inc.	100.00%	63,233	63,233	7
8	V	34	Rent Expense		Nivram Management, Inc.	100.00%	22,212	22,212	8
9	V	26	Insurance		Nivram Management, Inc.	100.00%	2,255	2,255	9
10	V	20	Adversising		Nivram Management, Inc.	100.00%	75	75	10
11	V	22	Health Insurance		Nivram Management, Inc.	100.00%	18,398	18,398	11
12	V	7	Scavenger		Nivram Management, Inc.	100.00%	730	730	12
13	V	35	Rental Equipment		Nivram Management, Inc.	100.00%	93	93	13
14	Total			$			$ 122,629	$ * 122,629	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: 01/01/2014 Ending: 12/31/2014

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	Postage	$	Nivram Management, Inc.	100.00%	$ 878	$ 878	15
16	V	19	Professional Fees		Nivram Management, Inc.	100.00%	301	301	16
17	V	20	Licenses & Permits		Nivram Management, Inc.	100.00%	168	168	17
18	V	25	Travel Expense		Nivram Management, Inc.	100.00%	51	51	18
19	V	30	Depreciation		Nivram Management, Inc.	100.00%	1,490	1,490	19
20	V	21	Data Processing		Nivram Management, Inc.	100.00%	1,497	1,497	20
21	V	2	Sales Tax Expense		Nivram Management, Inc.	100.00%	2,028	2,028	21
22	V	22	Employee Welfare		Nivram Management, Inc.	100.00%	545	545	22
23	V	21	Telephone		Nivram Management, Inc.	100.00%	3,089	3,089	23
24	V	6	Plant Salary		Nivram Management, Inc.	100.00%	152,236	152,236	24
25	V	17	Office Manager Salary		Nivram Management, Inc.	100.00%	40,825	40,825	25
26	V	1	Food Service Supervisor Salary		Nivram Management, Inc.	100.00%	25,266	25,266	26
27	V	17	Administrative Salaries		Nivram Management, Inc.	100.00%	111,097	111,097	27
28	V	17	Administrator Salary		Nivram Management, Inc.	100.00%	229,176	229,176	28
29	V	21	Clerical Salaries		Nivram Management, Inc.	100.00%	127,624	127,624	29
30	V	6	Maintenance Salary		Nivram Management, Inc.	100.00%	100,000	100,000	30
31	V	17	Assistant Administrator		Nivram Management, Inc.	100.00%	228,355	228,355	31
32	V	17	Management Fees	1,147,255	Nivram Management, Inc.	100.00%		(1,147,255)	32
33	V	34	Rental Income	22,212	Hamlin & Arthur Partnership	100.00%		(22,212)	33
34	V	32	Interest Income	4	Hamlin & Arthur Partnership	100.00%		(4)	34
35	V	21	Bank Fees		Hamlin & Arthur Partnership	100.00%	103	103	35
36	V	30	Depreciation		Hamlin & Arthur Partnership	100.00%	15,394	15,394	36
37	V	33	Real Estate Taxes		Hamlin & Arthur Partnership	100.00%	14,072	14,072	37
38	V	34	Rental Income	1,860,000	BM of Chicago Ridge Real Estate, LLC	100.00%		(1,860,000)	38
39	Total			$ 3,029,471			$ 1,054,195	$ * (1,975,276)	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: 01/01/2014 Ending: 12/31/2014

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	$ 454	BM of Chicago Ridge Real Estate, LLC	100.00%	$	$ (454)	15
16	V	43	Other Income	16,460	BM of Chicago Ridge Real Estate, LLC	100.00%		(16,460)	16
17	V	21	Bank Charges		BM of Chicago Ridge Real Estate, LLC	100.00%	53	53	17
18	V	19	Accounting Fees		BM of Chicago Ridge Real Estate, LLC	100.00%	10,972	10,972	18
19	V	33	Real Estate Taxes		BM of Chicago Ridge Real Estate, LLC	100.00%	542,460	542,460	19
20	V	26	Insurance Expense		BM of Chicago Ridge Real Estate, LLC	100.00%	303,057	303,057	20
21	V	32	Interest Expense		BM of Chicago Ridge Real Estate, LLC	100.00%	443,408	443,408	21
22	V	30	Depreciation Expense		BM of Chicago Ridge Real Estate, LLC	100.00%	448,630	448,630	22
23	V	31	Amortization Expense		BM of Chicago Ridge Real Estate, LLC	100.00%	3,565	3,565	23
24	V	43	Loss on Disposition of Assets		BM of Chicago Ridge Real Estate, LLC	100.00%	210,692	210,692	24
25	V	21	Income Tax Benefit	1,112	BM of Chicago Ridge Real Estate, LLC	100.00%		(1,112)	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			$ 18,026			$ 1,962,837	$ * 1,944,811	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: 01/01/2014 Ending: 12/31/2014

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: 01/01/2014 Ending: 12/31/2014

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	166,667	13	33.33	Salary	$ 83,333	17-7	1
2	Louise Mermelstein	Dietary Supervisor	Support	0.00	50,533	7	33.34	Salary	25,266	1-7	2
3	Marvin Mermelstein	Plant Supervisor	Support	30.20	259,000	7	37.20	Salary	152,236	6-7	3
4	Doreen Mermelstein	Office Manager	Administrative	0.00	81,651	13	13.33	Salary	40,825	21-7	4
5											5
6	Marvin Mermelstein	Asst. Administrator	Administrative	See Above	388,500	10	37.20	Salary	228,355	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	359,013	19	44.03	Salary	95,013	17-7	8
9	Marvin Mermelstein Family		N/A	19.80							9
10	Joseph Mermelstein Family Trust		N/A	19.80							10
11											11
12											12
13								TOTAL	$ 652,792		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: 01/01/2014 Ending: 2/31/2014

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	$ 1,807	$	231	$ 669	1
2	6	Repairs & Maintenance	Resident Beds	624	3	2,463		231	912	2
3	5	Utilities	Resident Beds	624	3	17,611		231	6,519	3
4	21	Office	Resident Beds	624	3	12,600		231	4,664	4
5	20	Dues & Subscriptions	Resident Beds	624	3	7,626		231	2,823	5
6	21	Taxes - Other	Resident Beds	624	3	126		231	47	6
7	22	Payroll Taxes	Resident Beds	624	3	170,810		231	63,233	7
8	34	Rent	Resident Beds	624	3	60,000		231	22,212	8
9	26	Insurance	Resident Beds	624	3	6,092		231	2,255	9
10	20	Advertising	Resident Beds	624	3	202		231	75	10
11	22	Health Insurance	Resident Beds	624	3	49,699		231	18,398	11
12	7	Scavenger	Resident Beds	624	3	1,972		231	730	12
13	35	Rental Equipment	Resident Beds	624	3	250		231	93	13
14	21	Postage	Resident Beds	624	3	2,373		231	878	14
15	19	Professional Fees	Resident Beds	624	3	813		231	301	15
16	20	Licenses & Permits	Resident Beds	624	3	455		231	168	16
17	25	Travel Expense	Resident Beds	624	3	138		231	51	17
18	30	Depreciation Expense	Resident Beds	624	3	4,024		231	1,490	18
19	21	Data Processing	Resident Beds	624	3	4,044		231	1,497	19
20	2	Sales Tax Expense	Resident Beds	624	3	5,479		231	2,028	20
21	22	Employee Welfare	Resident Beds	624	3	1,473		231	545	21
22	21	Telephone	Resident Beds	624	3	8,343		231	3,089	22
23	6	Plant Salary	Direct Cost	1	1	152,236	152,236	1	152,236	23
24	17	Office Manager Salary	Direct Cost	1	1	40,825	40,825	1	40,825	24
25	TOTALS					$ 551,461	$ 193,061		$ 325,738	25

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

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	1	Food Service Supervisor Salary	Direct Cost	1	1	$ 25,266	$ 25,266	1	$ 25,266	1
2	17	Administrative Salaries	Direct Cost	1	1	111,097	111,097	1	111,097	2
3	17	Administrator Salary	Direct Cost	1	1	229,176	229,176	1	229,176	3
4	21	Clerical Salary	Direct Cost	1	1	127,624	127,624	1	127,624	4
5	6	Maintenance Salary	Direct Cost	1	1	100,000	100,000	1	100,000	5
6	17	Assistant Administrator	Direct Cost	1	1	228,355	228,355	1	228,355	6
7	21	Bank Fees	Resident Beds	624	3	280		231	104	7
8	30	Depreciation Expense	Resident Beds	624	3	41,584		231	15,394	8
9	33	Real Estate Taxes	Resident Beds	624	3	38,014		231	14,072	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 901,396	$ 821,518		$ 851,088	25

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	Berkeley Point Capital LLC		X	Mortgage	$123,479.00	5/22/2012	$ 13,345,000	$ 12,829,886	5/22/2047	3.4300	$ 443,408	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	$ 12,829,886			$ 443,408	9
	B. Non-Facility Related*											
10	Credit Card		X	Financing	n/a	n/a	n/a	n/a	n/a	n/a	35	10
11	Offset Agains Int Inc										(4)	11
12	Offset Agains Int Inc										(454)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (423)	14
15	TOTALS (line 9+line14)						$ 13,345,000	$ 12,829,886			$ 442,985	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 64,104 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:** 01/01/2014 **Ending:** 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	522,378	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.)	$	528,564	2
3. Under or (over) accrual (line 2 minus line 1).	$	6,186	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)	$	534,788	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.)**	$	15,558	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.	$	556,532	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2009	390,040	8
2010	400,687	9
2011	499,259	10
2012	529,314	11
2013	558,693	12

During the year, Chicago Ridge hired Bupdlaw firm to aqppeal its real estate taxes. The savings from this appeal are paid in 3 equal installments. In 2014 the Company paid $14,563.34 and $994.18. The 2nd and 3rd installments will be bileld in 2015 and 2016 respectfully.

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2013	$	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.**

2013 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 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	24-18-101-025-0000	Nursing Home	$ 372,595.19	$ 372,595.19
2.	24-18-101-039-0000	Nursing Home	$ 141,896.00	$ 141,896.00
3.	10-35-325-029-0000	Management Company	$ 4,151.28	$ 1,321.62
4.	10-35-325-015-0000	Management Company	$ 40,050.85	$ 12,750.80
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 558,693.32	$ 528,563.61

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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: 01/01/2014 Ending: 12/31/2014

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	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: 01/01/2014 Ending: 12/31/2014

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	$ 255,500	20-40	$ 255,500	$	$ 1,894,962	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sign			2001	1,419	236	27.5	236		676	9
10	Carpet			2002	2,240	359	27.5	359		1,024	10
11	Alarm			2002	22,000	3,444	27.5	3,444		9,766	11
12	Washer & Dryer			2002	29,304	20,381	27.5	20,381		29,306	12
13	Phone System			2002	10,667	1,651	27.5	1,651		4,669	13
14	A/C System			2002	11,200	1,733	27.5	1,733		4,903	14
15	Electrical Improvements			2002	3,000	464	27.5	464		1,314	15
16	Light Fixtures			2002	10,192	1,577	27.5	1,577		4,465	16
17	RC Alarm			2003	4,500	682	27.5	682		1,921	17
18	Water Heater			2003	16,500		5			16,500	18
19	Boiler			2004	21,500	2,857	27.5	2,857		7,821	19
20	Paving Improvements			2005	21,800	1,453	27.5	1,453		14,051	20
21	Bathroom Improvements			2005	634	80	27.5	80		216	21
22	Fire Smoke Dampers			2005	3,475	458	27.5	458		1,252	22
23	Boiler			2005	11,960		5			11,960	23
24	Locks			2006	4,374	491	27.5	491		1,285	24
25	Fire Alarm System			2006	98,711	11,087	27.5	11,087		29,015	25
26	AC Chiller Unit			2006	81,000	9,749	27.5	9,749		26,015	26
27	Furnance			2007	13,500	1,492	27.5	1,492		3,886	27
28	Temp Reset Control for Boiler			2007	2,750	302	27.5	302		782	28
29	Faucets			2007	2,298	252	27.5	252		655	29
30	Electrical Disconnect for Chiller Unit			2007	8,000	877	27.5	877		2,278	30
31	Add'l Amount for '06 AC Chiller Unit			2007	8,000	870	27.5	870		2,254	31
32	Hot Water Storage Tank			2007	22,000	2,353	27.5	2,353		6,066	32
33	Control System for New Chiller			2007	1,191	129	27.5	129		334	33
34	Grab Bars			2007	4,941	528	27.5	528		1,363	34
35	Boiler Room Change-Over Valves			2007	8,380	889	27.5	889		2,286	35
36	Water Cooler, attached to Building			2007	1,087	119	27.5	119		310	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: 01/01/2014 Ending: 12/31/2014

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	$ 319	27.5	$ 319	$	$ 807	37
38	Exhaust Fans	2009	7,098	601	27.5	601		1,420	38
39	Sprinkler System	2010	239,314	5,983	27.5	5,983		13,959	39
40	Boiler	2010	47,900	1,198	27.5	1,198		2,474	40
41	Electrical Breakers	2010	7,000	175	27.5	175		407	41
42	Fire Alarm	2011	8,982	225	27.5	225		825	42
43	Therapy Room - Flooring, Cabinets, Countertops	2011	2,635	166	27.5	166		334	43
44	Water Heater	2011	8,170	817	10	817		3,268	44
45	Sprinkler System	2011	4,000	100	27.5	100		308	45
46	Sprinkler System	2012	6,370	160	27.5	160		567	46
47	Laminate Flooring	2012	4,768	267	27.5	267		471	47
48	Stairway Exit Doors	2012	9,097	453	27.5	453		569	48
49	Water Pump	2013	2,625	119	27.5	119		176	49
50	Power Conditioner	2013	5,600	140	27.5	140		245	50
51	Elevator	2013	147,995	3,700	27.5	3,700		6,167	51
52	Roof Replacement	2013	152,325	3,808	27.5	3,808		5,077	52
53	Parking Lot Repavement	2013	7,100	178	27.5	178		222	53
54	Smoking Shelter	2013	4,053	101	27.5	101		118	54
55	Wiring Upgrade	2014	6,378	193	27.5	193		193	55
56	Water Pump	2014	4,100	25	27.5	25		25	56
57	Water Heater	2014	8,373	140	27.5	140		140	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)		$ 11,050,587	$ 338,881		$ 338,881	$	$ 2,119,107	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: 01/01/2014 Ending: 12/31/2014

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	$ 15,554	$ 15,554	$	5	$ 109,231	71
72	Current Year Purchases	25,385	1,048	1,048		5	1,048	72
73	Fully Depreciated Assets	62,113					62,113	73
74	Management & Real Estate Co.	1,764,084	193,289	193,289		10		74
75	TOTALS	$ 1,955,268	$ 209,891	$ 209,891	$		$ 172,392	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)	$ 13,440,855	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 548,772	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 548,772	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)	$ 2,291,499	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: 01/01/2014 Ending: 12/31/2014

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. [ ] YES [X] 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.	12/31/2015	$ 1,860,000
13.	12/31/2016	$ 1,860,000
14.	12/31/2017	$ 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: $ 2,098 Description: Copier - $2,005; Management Company - Copier - $93
(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: 01/01/2014 Ending: 12/31/2014

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: 01/01/2014 Ending: 12/31/2014

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			417,065			417,065	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):									12
13	Other (specify): Attached Schedule						2,989		2,989	13
14	TOTAL			$		$ 417,065	$ 2,989		$ 420,054	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:** 01/01/2014 **Ending:** 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2014 **(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	$ 326,771	$ 516,657	1
2	Cash-Patient Deposits	82,796	82,796	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,343,126	2,343,126	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,059	148,713	6
7	Other Prepaid Expenses	33,075	33,075	7
8	Accounts Receivable (owners or related parties)	107,145	107,145	8
9	Other(specify):		613,426	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,919,972	$ 3,844,938	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		9,686,666	14
15	Leasehold Improvements, at Historical Cost	408,698	1,047,507	15
16	Equipment, at Historical Cost	248,948	2,013,032	16
17	Accumulated Depreciation (book methods)	(338,223)	(3,542,421)	17
18	Deferred Charges		115,282	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)**	$ 319,423	$ 9,755,066	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,239,395	$ 13,600,004	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 285,104	$ 287,849	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	81,058	81,058	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	86,349	86,349	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		534,788	32
33	Accrued Interest Payable		36,672	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Attached Schedule	5,006,904	5,027,018	36
37	Due to Related Parties		4,041	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,459,415	$ 6,057,775	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,829,886	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)**	$	$ 12,829,886	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,459,415	$ 18,887,661	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,220,020)	$ (5,287,657)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,239,395	$ 13,600,004	48

***(See instructions.)**

Facility Name & ID Number Chicago Ridge Nursing Center **#** 0045815 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,811,758)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,811,758)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,481,738	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	(2,890,000)	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)**	$ (408,262)	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)**	$ (2,220,020)	24 *

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 11,659,383	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,659,383	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	78,751	6
7	Oxygen	3,830	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 82,581	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Income	550	28
28a	Miscellaneous Income	65,431	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 65,981	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,807,945	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	9,326,484	31
32	Health Care		32
33	General Administration		33
	B. Capital Expense		
34	Ownership		34
	C. Ancillary Expense		
35	Special Cost Centers		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)***	$ 9,326,484	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,481,461	41
42	**Income Taxes**	277	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,481,738	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: 01/01/2014 Ending: 12/31/2014

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	2,415	2,551	$ 88,343	$ 34.63	1
2	Assistant Director of Nursing					2
3	Registered Nurses	31,727	32,465	863,227	26.59	3
4	Licensed Practical Nurses	14,820	14,820	310,540	20.95	4
5	CNAs & Orderlies	64,820	67,284	678,166	10.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	24	24	288	12.00	8
9	Activity Director	1,558	1,678	30,706	18.30	9
10	Activity Assistants	7,361	8,055	79,040	9.81	10
11	Social Service Workers	8,481	8,952	167,213	18.68	11
12	Dietician					12
13	Food Service Supervisor	3,681	3,952	49,954	12.64	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,794	25,907	280,409	10.82	15
16	Dishwashers					16
17	Maintenance Workers	4,209	4,353	47,961	11.02	17
18	Housekeepers	26,735	28,988	288,574	9.95	18
19	Laundry	9,563	10,504	106,092	10.10	19
20	Administrator					20
21	Assistant Administrator	2,080	2,160	58,789	27.22	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,615	3,668	35,209	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	1,984	2,112	21,864	10.35	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	206,867	217,473	$ 3,106,375 *	$ 14.28	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	$ 9,927	1-3	35
36	Medical Director	O			36
37	Medical Records Consultant	N			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	3,357	12-3	45
46	Other(specify)	S			46
47	Psycho Social		1,246	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 14,530		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 271,828	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$ 271,828		53

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Darlene Guzy	Assistant Admin	0.0	$ 58,789
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 58,789

B. Administrative - Other

Description	Amount
Management Fees	$ 1,147,255
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,147,255
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
See Attached Schedule		87,918
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 87,918

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 63,181
Unemployment Compensation Insurance	41,645
FICA Taxes	238,148
Employee Health Insurance	39,418
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Dental Insurance	1,091
Allocation from Management Company	82,176
TOTAL (agree to Schedule V, line 22, col.8)	$ 465,659

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	4,320
Health Care Worker Background Check	
(Indicate # of checks performed 36)	1,170
Patient Background Checks 194	1,050
Dues & Subscriptions	2,703
Licenses & Permits	2,909
Advertising	447
Allocation from Management Company	3,066
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(447)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,218

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,320
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,320

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	N/A		$		$	$	$	$	$	$	$	$	$
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:** 01/01/2014 **Ending:** 12/31/2014

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. $ **575,640**
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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees