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.

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

I. IDPH License ID Number: 0039255

Facility Name: Park Ridge Care Center

Address: 665 Busse Highway (Number) Park Ridge (City) 60068 (Zip Code)

County: Cook

Telephone Number: (847) 679-8219 **Fax #** (847) 679-7377

HFS ID Number:

Date of Initial License for Current Owners: 12/1/1993

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
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 01/01/14 to 12/31/14 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) Lisa M. Hanlon, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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 Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 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	46	Skilled (SNF)	46	16,790	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	46	TOTALS	46	16,790	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	1,395		1,592	2,987	8
9	SNF/PED					9
10	ICF	9,309	153	2,779	12,241	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,704	153	4,371	15,228	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.70%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 12/1/1993

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/1/1993 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 46 and days of care provided 1,461

Medicare Intermediary Wisconsin Physician 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 Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	171,347	11,225	1,005	183,577		183,577		183,577			1
2	Food Purchase		69,112		69,112	(544)	68,568	(7)	68,561			2
3	Housekeeping	62,895	14,221		77,116		77,116		77,116			3
4	Laundry	42,185	7,312		49,497		49,497		49,497			4
5	Heat and Other Utilities			39,590	39,590		39,590	(893)	38,697			5
6	Maintenance	41,920	26,442	27,831	96,193		96,193	63,877	160,070			6
7	Other (specify):*							76	76			7
8	TOTAL General Services	318,347	128,312	68,426	515,085	(544)	514,541	63,053	577,594			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	890,330	50,538	8,833	949,701		949,701		949,701			10
10a	Therapy		146		146		146		146			10a
11	Activities		9,669	1,290	10,959		10,959		10,959			11
12	Social Services	20,943		1,209	22,152		22,152		22,152			12
13	CNA Training											13
14	Program Transportation			2,040	2,040		2,040		2,040			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	911,273	60,353	19,372	990,998		990,998		990,998			16
	C. General Administration											
17	Administrative	108,192			108,192		108,192	18,695	126,887			17
18	Directors Fees											18
19	Professional Services			82,367	82,367	(21,680)	60,687	(35,492)	25,195			19
20	Dues, Fees, Subscriptions & Promotions			19,462	19,462		19,462	(10,243)	9,219			20
21	Clerical & General Office Expenses		8,737	344,318	353,055		353,055	(306,569)	46,486			21
22	Employee Benefits & Payroll Taxes			163,486	163,486	544	164,030		164,030			22
23	Inservice Training & Education											23
24	Travel and Seminar			920	920		920	362	1,282			24
25	Other Admin. Staff Transportation			7,412	7,412		7,412	1,303	8,715			25
26	Insurance-Prop.Liab.Malpractice			60,147	60,147		60,147	1,899	62,046			26
27	Other (specify):*							7,531	7,531			27
28	TOTAL General Administration	108,192	8,737	678,112	795,041	(21,136)	773,905	(322,514)	451,391			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,337,812	197,402	765,910	2,301,124	(21,680)	2,279,444	(259,461)	2,019,983			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 Park Ridge Care Center #0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			23,180	23,180		23,180	56,191	79,371			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			750	750		750	80,224	80,974			32
33	Real Estate Taxes					21,680	21,680	212,709	234,389			33
34	Rent-Facility & Grounds			370,000	370,000		370,000	(370,000)				34
35	Rent-Equipment & Vehicles			6,184	6,184		6,184	3,668	9,852			35
36	Other (specify):*							6,145	6,145			36
37	**TOTAL Ownership**			400,114	400,114	21,680	421,794	(11,063)	410,732			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		37,355	157,355	194,710		194,710		194,710			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			108,611	108,611		108,611		108,611			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		37,355	265,966	303,321		303,321		303,321			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,337,812	234,757	1,431,990	3,004,559		3,004,559	(270,523)	2,734,036			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 Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	(1,290)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(13,522)	30		9
10	Interest and Other Investment Income	(30)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(7)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(300)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(64,000)	21		24
25	Fund Raising, Advertising and Promotional	(2,729)	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	(234,126)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (316,003)		$	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)	45,480		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 45,480		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (270,523)		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

Park Ridge Care Center

ID# 0039255

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sequestration Expense	$ (12,410)	21	1
2	Bank Charges	(702)	21	2
3	State Replacement Tax	(1,194)	21	3
4	Building Co. - Amortization	(2,821)	31	4
5	Building Co. - Taxes	(1,029)	21	5
6	Building Co. - Accounting Fee	(10,677)	19	6
7	Building Co. - Entity Expense	(1,040)	21	7
8	Additional R&M	61,641	06	8
9	PPA - Other Income	(94)	21	9
10	PPA - Office Expenses	(1,918)	21	10
11	PPA - Various write-off accounts	(162,042)	21	11
12	PPA - Prior Period Rent Expense	(92,617)	21	12
13	PPA - Advertising and Promotion	(5,795)	20	13
14	PAC Dues	(2,428)	20	14
15	Capitalized R&M	(1,000)	06	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**	(234,126)		49

Park Ridge Care Center

ID# 0039255

Report Period Beginning: 01/01/14

Ending: 12/31/14

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

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park Ridge Care Center **#** 0039255 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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													1
2	Food Purchase	(7)											(7)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(1,290)		397									(893)	5
6	Maintenance	60,641	875	2,361									63,877	6
7	Other (specify):*			76									76	7
8	**TOTAL General Services**	59,344	875	2,834									63,053	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**													16
	C. General Administration													
17	Administrative				18,695								18,695	17
18	Directors Fees													18
19	Professional Services	(10,677)	10,677	(35,492)									(35,492)	19
20	Fees, Subscriptions & Promotions	(11,252)		1,009									(10,243)	20
21	Clerical & General Office Expenses	(337,046)	2,069	25,101	3,307								(306,569)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			362									362	24
25	Other Admin. Staff Transportation			1,303									1,303	25
26	Insurance-Prop.Liab.Malpractice		2,349	(450)									1,899	26
27	Other (specify):*			4,460		3,071							7,531	27
28	**TOTAL General Administration**	(358,975)	15,095	(3,707)	22,002	3,071							(322,514)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(299,631)	15,970	(873)	22,002	3,071							(259,461)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park Ridge Care Center **#** 0039255 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(13,522)	68,923	790									56,191	30
31	Amortization of Pre-Op. & Org.	(2,821)	2,821											31
32	Interest	(30)	79,576	678									80,224	32
33	Real Estate Taxes		211,350	1,359									212,709	33
34	Rent-Facility & Grounds		(370,000)										(370,000)	34
35	Rent-Equipment & Vehicles			3,668									3,668	35
36	Other (specify):*		6,145										6,145	36
37	**TOTAL Ownership**	(16,373)	(1,185)	6,495									(11,063)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(316,003)	14,785	5,622	22,002	3,071							(270,523)	45

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	34	Rental Income	$ 370,000	665 Busse Highway Limited Partnership		$	$ (370,000)	1
2	V	32	Interest Income	318	665 Busse Highway Limited Partnership			(318)	2
3	V	31	Amortization		665 Busse Highway Limited Partnership		2,821	2,821	3
4	V	30	Depreciation		665 Busse Highway Limited Partnership		68,923	68,923	4
5	V	36	MIP Insurance		665 Busse Highway Limited Partnership		6,145	6,145	5
6	V	33	Real Estate Taxes		665 Busse Highway Limited Partnership		211,350	211,350	6
7	V	06	Repairs and Maintenance		665 Busse Highway Limited Partnership		875	875	7
8	V	26	Insurance		665 Busse Highway Limited Partnership		2,349	2,349	8
9	V	32	Interest Expense-Midland		665 Busse Highway Limited Partnership		79,894	79,894	9
10	V	21	Taxes - Income		665 Busse Highway Limited Partnership		1,029	1,029	10
11	V	19	Accounting		665 Busse Highway Limited Partnership		10,677	10,677	11
12	V	21	Entity Expense		665 Busse Highway Limited Partnership		1,040	1,040	12
13	V								13
14	Total			$ 370,318			$ 385,103	$ * 14,785	14

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

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	5	UTILITIES	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 397	$ 397	15
16	V	6	REPAIRS & MAINT.		DYNAMIC HEALTH CARE CONS.	100.00%	2,361	2,361	16
17	V	7	EMP. BEN-GEN SERV.		DYNAMIC HEALTH CARE CONS.	100.00%	76	76	17
18	V	19	PROFESSIONAL FEES		DYNAMIC HEALTH CARE CONS.	100.00%	338	338	18
19	V	20	DUES AND SUBSCRIPTIONS		DYNAMIC HEALTH CARE CONS.	100.00%	1,009	1,009	19
20	V	21	CLERICAL & GENERAL		DYNAMIC HEALTH CARE CONS.	100.00%	25,101	25,101	20
21	V	24	SEMINARS AND TRAVEL		DYNAMIC HEALTH CARE CONS.	100.00%	362	362	21
22	V	25	AUTO EXP.		DYNAMIC HEALTH CARE CONS.	100.00%	1,303	1,303	22
23	V	26	INSURANCE		DYNAMIC HEALTH CARE CONS.	100.00%	(450)	(450)	23
24	V	27	EMP.BEN. - GEN. ADMIN.		DYNAMIC HEALTH CARE CONS.	100.00%	4,460	4,460	24
25	V	30	DEPRECIATION		DYNAMIC HEALTH CARE CONS.	100.00%	790	790	25
26	V	32	INTEREST		DYNAMIC HEALTH CARE CONS.	100.00%	678	678	26
27	V	33	REAL ESTATE TAXES		DYNAMIC HEALTH CARE CONS.	100.00%	1,359	1,359	27
28	V	19	REAL ESTATE TAX PROTEST FEES		DYNAMIC HEALTH CARE CONS.	100.00%	170	170	28
29	V	35	AUTO RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	3,641	3,641	29
30	V	35	EQUIPMENT RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	27	27	30
31	V								31
32	V	19	BOOKKEEPING FEES	36,000	DYNAMIC HEALTH CARE CONS.	100.00%		(36,000)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 36,000			$ 41,622	$ * 5,622	39

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

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$	$	15
16	V	17	ADMIN. CMP. - M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	7,087	7,087	16
17	V	17	ADMIN. CMP. - M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			17
18	V	17	ADMIN. CMP. - F. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			18
19	V	17	ADMIN. CMP. - D. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			19
20	V	17	ADMIN. CMP. - S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%			20
21	V	17	ADMIN. CMP. - S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%			21
22	V	17	ADMIN. CMP. - D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%			22
23	V	17	ADMIN. CMP. - H. ALTER		DYNAMIC HEALTH CARE CONS.	100.00%			23
24	V	17	ADMIN. CMP. - V. DAVIS (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	4,522	4,522	24
25	V	17	ADMIN. CMP. - VAR. (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%			25
26	V	17	ADMIN. CMP. - CFO (NON-OWNER) .		DYNAMIC HEALTH CARE CONS.	100.00%	7,086	7,086	26
27	V	21	CLERICAL CMP. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	3,092	3,092	27
28	V	21	CLERICAL CMP. - E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	215	215	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			$			$ 22,002	$ * 22,002	39

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

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	7	EMP. BEN.- D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$	$	15
16	V	27	EMP. BEN.- M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	407	407	16
17	V	27	EMP. BEN.- M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			17
18	V	27	EMP. BEN.- F. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			18
19	V	27	EMP. BEN.- D. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			19
20	V	27	EMP. BEN.- S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%			20
21	V	27	EMP. BEN.- S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%			21
22	V	27	EMP. BEN.- D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%			22
23	V	27	EMP. BEN.- H. ALTER		DYNAMIC HEALTH CARE CONS.	100.00%			23
24	V	27	EMP. BEN.-V. DAVIS (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	1,097	1,097	24
25	V	27	EMP. BEN.- NON-OWNER		DYNAMIC HEALTH CARE CONS.	100.00%			25
26	V	27	EMP. BEN.- CFO (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	859	859	26
27	V	27	EMP. BEN. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	598	598	27
28	V	27	EMP. BEN. - E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	110	110	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			$			$ 3,071	$ * 3,071	39

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

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 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			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	FREIDA MAUER	50.000%	BRIDGEVIEW HEALTH CARE CENTER, LTD.	BRIDGEVIEW	665 BUSSE HIGHWAY LIMITED PARTNERSHIP		BUILDING CO.	1
2	JOSEPH MAUER	25.000%	GROSSE POINTE MANOR, L.L.C.	NILES	DYNAMIC HEALTH CARE	SKOKIE	BOOKEEPING/CONSULT	2
3	SPRINTZA MAUER	25.000%	OTTAWA PAVILION, LTD.	OTTAWA	SEASONS HOSPICE	PARK RIDGE	HOSPICE	3
4			STERLING PAVILION, LTD.	STERLING	LIFELINE AMBULANCE, LLC	CHICAGO	AMBULANCE	4
5			WARREN PARK HEALTH AND LIVING CENTER,LLC	CHICAGO				5
6			WATERFRONT TERRACE, INC.	CHICAGO				6
7			WILLOW CREST NURSING PAVILION, LTD.	SANDWICH				7
8			WINDMILL NURSING PAVILION, LTD.	SOUTH HOLLAND				8
9			WOODBRIDGE NURSING PAVILION, LTD.	CHICAGO				9
10			WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF GALESBURG (	GALESBURG				10
11			WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF GENESEO (SLI	GENESEO				11
12			WOODRIDGE SUPPORTIVE LIVING RESIDENCE OF PONTIAC (SLF	PONTIAC				12
13			RIVER NORTH OF BRADLEY HEALTH & REHAB	BRADLEY				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 Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Marshall Mauer	Relative	Administrative	0%	See Attached	1.42	2.84%	Alloc. Salary	$ 7,087	17-07	1
2	Esther Maryles	Relative	Administrative	0%	See Attached	0.1	0.36%	Alloc. Salary	215	21-07	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 7,302		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 Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	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	5	UTILITIES	PATIENT DAYS	452,396	14	$ 11,795	$	15,228	$ 397	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	452,396	14	70,149	38,885	15,228	2,361	2
3	7	EMP. BEN-GEN SERV.	PATIENT DAYS	452,396	14	2,266		15,228	76	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	452,396	14	10,039		15,228	338	4
5	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	452,396	14	29,965		15,228	1,009	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	452,396	14	745,706	528,878	15,228	25,101	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	452,396	14	10,766		15,228	362	7
8	25	AUTO EXP.	PATIENT DAYS	452,396	14	38,698		15,228	1,303	8
9	26	INSURANCE	PATIENT DAYS	452,396	14	(13,379)		15,228	(450)	9
10	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	452,396	14	132,506		15,228	4,460	10
11	30	DEPRECIATION	PATIENT DAYS	452,396	14	23,478		15,228	790	11
12	32	INTEREST	PATIENT DAYS	452,396	14	20,148		15,228	678	12
13	33	REAL ESTATE TAXES	PATIENT DAYS	452,396	14	40,366		15,228	1,359	13
14	19	REAL ESTATE TAX PROTEST	PATIENT DAYS	452,396	14	5,056		15,228	170	14
15	35	AUTO RENTAL	PATIENT DAYS	452,396	14	108,178		15,228	3,641	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	452,396	14	802		15,228	27	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,236,539	$ 567,763		$ 41,622	25

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	9	59,284	59,284	-		1
2	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	11	200,000	200,000	1.42	7,087	2
3	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	9	200,000	200,000	-		3
4	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	5	11,000	11,000	-		4
5	17	ADMIN. CMP. - D. AARON	WGHTD. AVG. HOURS	40	3	60,271	60,271	-		5
6	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	103,196	103,196	-		6
7	17	ADMIN. CMP. - S. HARAMARA	WGHTD. AVG. HOURS	30	4	76,737	76,737	-		7
8	17	ADMIN. CMP. - D. KUFTA	WGHTD. AVG. HOURS	50	9	150,258	150,258	-		8
9	17	ADMIN. CMP. - H. ALTER	WGHTD. AVG. HOURS	40	1	12,000	12,000	-		9
10	17	ADMIN. CMP. - V. DAVIS (NON	WGHTD. AVG. HOURS	40	11	127,632	127,632	1.42	4,522	10
11	17	ADMIN. CMP. - VAR. (NON-OW	WGHTD. AVG. HOURS	45	9	129,197	129,197	-		11
12	17	ADMIN. CMP. - CFO (NON-OW	WGHTD. AVG. HOURS	40	11	200,000	200,000	1.42	7,086	12
13	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	11	87,119	87,119	1.42	3,092	13
14	21	CLERICAL CMP. - E. MARYLE	WGHTD. AVG. HOURS	28	12	60,541	60,541	0.10	215	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,477,235	$ 1,477,235		$ 22,002	25

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	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	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40	9	6,150		-		1
2	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	11	11,498		1.42	407	2
3	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	9	14,402		-		3
4	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	5	37,628		-		4
5	27	EMP. BEN.- D. AARON	WGHTD. AVG. HOURS	40	3	4,909		-		5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	37,033		-		6
7	27	EMP. BEN.- S. HARAMARAS	WGHTD. AVG. HOURS	30	4	25,836		-		7
8	27	EMP. BEN.- D. KUFTA	WGHTD. AVG. HOURS	50	9	10,754		-		8
9	27	EMP. BEN.- H. ALTER	WGHTD. AVG. HOURS	40	1	1,085		-		9
10	27	EMP. BEN.-V. DAVIS (NON-OW	WGHTD. AVG. HOURS	40	11	30,956		1.42	1,097	10
11	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	9	40,985		-		11
12	27	EMP. BEN.- CFO (NON-OWNEF	WGHTD. AVG. HOURS	40	11	24,244		1.42	859	12
13	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	11	16,859		1.42	598	13
14	27	EMP. BEN. - E. MARYLES	WGHTD. AVG. HOURS	28	12	30,999		0.10	110	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 293,338	$		$ 3,071	25

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Midland		X	Mortgage			$	$ 1,214,787			$ 79,894	1
2	Allocated from Dynamic	X									678	2
3												3
4												4
5												5
	Working Capital											
6	MB Financial		X	Line of Credit							750	6
7												7
8												8
9	TOTAL Facility Related						$	$ 1,214,787			$ 81,322	9
	B. Non-Facility Related*											
10	Interest Income		X								(30)	10
11	Interest Income-Bldg Co.		X								(318)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (348)	14
15	TOTALS (line 9+line14)						$	$ 1,214,787			$ 80,974	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 6,145 Line # 36

* 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 Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.**	$ 149,000	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.)		$ 179,709	2
3. Under or (over) accrual (line 2 minus line 1).		$ 30,709	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 182,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ 21,680	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** $ 63,872 **For** 2011-12 **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.		$ 234,390	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	128,115	8
	2010	137,418	9
	2011	139,204	10
	2012	146,366	11
	2013	178,350	12

2014 Accrual - $178,350 x 1.02 = $181,917 (Rounded)

Allocated from Dynamic - $1,359

	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 Park Ridge Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0039255

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 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.	09-27-213-053-0000	Long Term Care Property	$ 178,350.32	$ 178,350.32
2.	10-23-404-059-0000	Allocated from Dynamic	$ 39,907.32	$ 1,343.31
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 218,257.64	$ 179,693.63

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park Ridge Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0039255

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2000 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 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 13,300 B. General Construction Type: Exterior Brick Frame Steel Stud Number of Stories 1

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

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

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

None

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	Facility			$ 49,000	1
2					2
3	TOTALS			$ 49,000	3

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	46		1986	1961	$ 1,323,000	$ 68,923	39	$ 33,923	$ (35,000)	$ 713,797	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1994	8,310		20	180	180	7,378	9
10	Various			1995	33,691		20	1,685	1,685	29,965	10
11	Various			1997	21,547		20	1,077	1,077	18,069	11
12	Various			1998	18,893		20	945	945	15,340	12
13	Various			1999	7,527		20	376	376	5,824	13
14	Various			2000	68,323		20	3,376	3,376	49,012	14
15	Various			2001	3,525		20	81	81	2,976	15
16	Various			2002	5,638		20	185	185	4,251	16
17	Various			2003	24,130		20	465	465	21,015	17
18	Various			2004	3,490		20	175	175	1,823	18
19	Various			2005	1,858		20	93	93	877	19
20	Various			2006	6,500		20	325	325	2,683	20
21	Various			2008	11,545		20	1,002	1,002	6,664	21
22	Various			2010	6,813		20	273	273	1,238	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

*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 Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		220,873			10,392	10,392	64,720	67
68	Related Party Allocations (Pages 12H & 12I)		14,932	383		427	44	9,101	68
69	Financial Statement Depreciation			23,180			(23,180)		69
70	TOTAL (lines 4 thru 69)		$ 1,780,596	$ 92,486		$ 54,979	$ (37,507)	$ 954,734	70

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

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	
1	Totals from Page 12A, Carried Forward		$ 1,780,596	$ 92,486		$ 54,979	$ (37,507)	$ 954,734	1
2	Roof And Air Cond	2011	2,500		20	64	64	227	2
3	Asphalt Work	2011	9,465		20	243	243	779	3
4	Replace Sprinkler Heads	2012	4,750		20	122	122	340	4
5	Fire Alarm System	2012	20,310		20	521	521	1,410	5
6	Sprinkler System Hydraulic Placard	2013	5,920		20	152	152	285	6
7	Security Cameras	2014	2,580		20	215	215	215	7
8	Remodeling Supplies- Windows Installation	2014	2,760		20	184	184	184	8
9	Replace Gutters And Repair Roof Covering	2014	4,300		20	215	215	215	9
10	Laundry, Hallway, Kitchen-Remove & Install Stud Walls, Fire Rat	2014	19,625		20	981	981	981	10
11	Tuckpointing/Painting	2014	5,000		20	333	333	333	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,857,806	$ 92,486		$ 58,009	$ (34,477)	$ 959,703	34

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

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	
1	Totals from Page 12B, Carried Forward		$ 1,857,806	$ 92,486		$ 58,009	$ (34,477)	$ 959,703	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,857,806	$ 92,486		$ 58,009	$ (34,477)	$ 959,703	34

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

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	
1	Totals from Page 12C, Carried Forward		$ 1,857,806	$ 92,486		$ 58,009	$ (34,477)	$ 959,703	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,857,806	$ 92,486		$ 58,009	$ (34,477)	$ 959,703	34

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

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	
1	Totals from Page 12D, Carried Forward		$ 1,857,806	$ 92,486		$ 58,009	$ (34,477)	$ 959,703	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
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16									16
17									17
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,857,806	$ 92,486		$ 58,009	$ (34,477)	$ 959,703	34

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

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	
1	Totals from Page 12E, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9	Flooring	2008	14,000		20	700	700	6,183	9
10	Nursing Station	2008	5,000		20	250	250	2,167	10
11	Nursing Station	2008	4,700		20	235	235	2,037	11
12	Econocare Call Light System	2008	12,011		20	601	601	5,607	12
13	Jacks & Son Asphalt Parking Lot	2008	16,033		20	802	802	6,682	13
14	Flooring	2008	15,578		20	779	779	6,232	14
15	Drop Ceiling & Lighting	2009	19,000		20	950	950	7,283	15
16	Roof Rubber Installation	2009	3,000		20	150	150	1,075	16
17	Lobby - Wallpaper, Vinyl Tile, Millwork, Cove Base	2010	4,185		20	209	209	1,045	17
18	Conference Room - Wallpaper, Vinyl Tile, Millwork, Cove Base	2010	3,909		20	195	195	6,069	18
19	Corridor - Wallpaper, Vinyl Tile, Millwork, Cove Base	2010	19,821		20	991	991	4,955	19
20	Various Areas:Wallcovering, Vinyl Flr, Paint (Drs, Drframes, & W	2010	48,069		20	2,403	2,403	12,016	20
21	Door	2011	11,077		20	46	46	184	21
22	Double Entry Kitchen Door	2011	3,450		20	29	29	116	22
23	Built-In Cabinet and Countertop	2011	6,775		20	339	339	1,356	23
24	Remodeling of 2 Bathrooms	2013	19,965		20	998	998	998	24
25	Roof Replacement	2013	14,300		20	715	715	715	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 220,873	$		$ 10,392	$ 10,392	$ 64,720	34

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

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	
1	Totals from Page 12F, Carried Forward		$ 220,873	$		$ 10,392	$ 10,392	$ 64,720	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 220,873	$		$ 10,392	$ 10,392	$ 64,720	34

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

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	
1	Totals from Page 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Dynamic	1993	14,932	383	20	427	44	9,101	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 14,932	$ 383		$ 427	$ 44	$ 9,101	34

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

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	
1	Totals from Page 12H, Carried Forward		$ 14,932	$ 383		$ 427	$ 44	$ 9,101	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
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20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 14,932	$ 383		$ 427	$ 44	$ 9,101	34

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

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 116,297	$ 21	$ 19,099	$ 19,078	10	$ 76,275	71
72	Current Year Purchases	5,124	217	935	718	10	935	72
73	Fully Depreciated Assets	191,741		16	16	10	191,708	73
74								74
75	TOTALS	$ 313,162	$ 238	$ 20,049	$ 19,811		$ 268,917	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Dynamic	2014	$ 7,934	$ 169	$ 1,313	$ 1,144	5	$ 5,009	76
77										77
78										78
79										79
80	TOTALS			$ 7,934	$ 169	$ 1,313	$ 1,144		$ 5,009	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)	$ 2,227,902	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 92,893	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 79,371	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (13,522)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,233,629	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	Construction in Progress	$ 32,000	92
93			93
94			94
95		$ 32,000	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 Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2015	$
13.	/2016	$
14.	/2017	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 3,105 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2015 Buick Enclave	$ 461.00	$ 3,106	17
18	Allocated from Dynamic			3,641	18
19					19
20					20
21	TOTAL		$ 461.00	$ 6,747	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 Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 75,447	$		$ 75,447	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			1,756			1,756	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			78,271			78,271	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				34,529		34,529	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					1,881	2,826		4,707	13
14	TOTAL			$		$ 157,355	$ 37,355		$ 194,710	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 Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/14 (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	$ 443,602	$ 485,371	1
2	Cash-Patient Deposits	57,364	57,364	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	903,248	903,248	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	35,951	36,564	6
7	Other Prepaid Expenses	6,602	6,602	7
8	Accounts Receivable (owners or related parties)	31,390	245,652	8
9	Other(specify):	56,087	489,040	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,534,244	$ 2,223,841	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		49,000	13
14	Buildings, at Historical Cost		1,323,000	14
15	Leasehold Improvements, at Historical Cost	382,907	574,401	15
16	Equipment, at Historical Cost	174,748	349,538	16
17	Accumulated Depreciation (book methods)	(368,204)	(1,315,663)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	41,348	96,203	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 230,799	$ 1,076,479	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,765,043	$ 3,300,320	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 144,619	$ 144,618	26
27	Officer's Accounts Payable	44,465	32,500	27
28	Accounts Payable-Patient Deposits	64,560	64,560	28
29	Short-Term Notes Payable		33,016	29
30	Accrued Salaries Payable	123,627	123,627	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,787	4,787	31
32	Accrued Real Estate Taxes(Sch.IX-B)		182,000	32
33	Accrued Interest Payable		6,580	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	99,895	99,895	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 481,953	$ 691,583	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,181,771	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)**	$	$ 1,181,771	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 481,953	$ 1,873,354	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,283,090	$ 1,426,966	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,765,043	$ 3,300,320	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,209,433	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,209,433	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	133,657	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	(60,000)	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)**	$ 73,657	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)**	$ 1,283,090	24	*

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

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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	$ 3,067,609	1
2	Discounts and Allowances for all Levels	(628,101)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,439,508	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	536,550	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 536,550	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	52,815	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,605	19
20	Radiology and X-Ray	502	20
21	Other Medical Services	4,240	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 69,162	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	30	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 30	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	92,966	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 92,966	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,138,216	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	515,085	31
32	Health Care	990,998	32
33	General Administration	795,041	33
	B. Capital Expense		
34	Ownership	400,114	34
	C. Ancillary Expense		
35	Special Cost Centers	194,710	35
36	Provider Participation Fee	108,611	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,004,559	40
41	**Income before Income Taxes (line 30 minus line 40)****	133,657	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 133,657	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,714,803	44
45	Private Pay - Net Inpatient Revenue	29,735	45
46	Medicare - Net Inpatient Revenue	248,497	46
47	Other-(specify) Hospice	247,749	47
48	Other-(specify) Medicaid Pending	198,724	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,439,508	49

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

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

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

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

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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	3,150	3,455	$ 136,578	$ 39.53	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,927	8,637	262,306	30.37	3
4	Licensed Practical Nurses	794	794	15,646	19.71	4
5	CNAs & Orderlies	31,579	34,349	470,636	13.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	1,115	1,291	20,943	16.22	11
12	Dietician					12
13	Food Service Supervisor	2,435	2,637	58,680	22.25	13
14	Head Cook	6,593	6,873	98,716	14.36	14
15	Cook Helpers/Assistants	1,225	1,308	13,951	10.67	15
16	Dishwashers					16
17	Maintenance Workers	1,845	1,934	41,920	21.68	17
18	Housekeepers	5,547	5,838	62,895	10.77	18
19	Laundry	3,050	3,289	42,185	12.83	19
20	Administrator	2,086	2,321	108,192	46.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					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	377	393	5,164	13.14	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	67,723	73,119	$ 1,337,812 *	$ 18.30	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	12	$ 1,005	01-03	35
36	Medical Director	104	6,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	48	2,145	10-03	38
39	Pharmacist Consultant	92	3,056	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	23	1,290	11-03	44
45	Social Service Consultant	20	1,209	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	298	$ 14,705		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	88	3,632	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	88	$ 3,632		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rob Weisz	Administrator	0	$ 108,192
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 108,192

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Dynamic HC Consultants	Bookkeeping	$ 36,000
Frost, Ruttenberg & Rothblatt	Accounting	16,775
Personnel Planners	Unemployment Consulting	685
Health Data Systems	Data Processing	4,994
See Attached	Legal	2,623
Skidelsky & Associates	R/E Tax Assessment	21,290
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 82,368

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 26,146
Unemployment Compensation Insurance	9,107
FICA Taxes	100,738
Employee Health Insurance	21,657
Employee Meals	544
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	5,838
TOTAL (agree to Schedule V, line 22, col.8)	$ 164,030

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	650
Health Care Worker Background Check	910
(Indicate # of checks performed 91)	
Patient Background Checks	
Dues and Subscriptions	3,413
Licenses & Permits	3,237
Allocated from Dynamic	1,009
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,219

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	920
Allocated from Dynamic	362
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,282

**See instructions.

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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		$		$	$	$	$	$	$	$	$	$

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC - $4,968**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **20,511** Line **10-02**

(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. $ **108,611**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(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. $ **544** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **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? **100% Ln 14**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **No**
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.