		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 0045815

Facility Name: Chicago Ridge Nursing Center

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

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners:

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Sanford B. Alper **Telephone Number:** (847) 580-4100
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2016 to 12/31/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

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

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 231

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	63,933	1,501	13,631	79,065	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	63,933	1,501	13,631	79,065	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.52%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 38 and days of care provided 9,693

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	361,686	24,736	56,779	443,201		443,201		443,201			1
2	Food Purchase		417,472		417,472		417,472	(499)	416,973			2
3	Housekeeping	249,316	27,901		277,217		277,217		277,217			3
4	Laundry	108,184	10,250		118,434		118,434		118,434			4
5	Heat and Other Utilities			216,538	216,538		216,538	3,485	220,023			5
6	Maintenance	30,751	42,416		73,167		73,167	35,935	109,102			6
7	Other (specify):*			22,933	22,933		22,933	165	23,098			7
8	TOTAL General Services	749,937	522,775	296,250	1,568,962		1,568,962	39,086	1,608,048			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,316,208	213,589	174,598	2,704,395		2,704,395		2,704,395			10
10a	Therapy	52,647			52,647		52,647		52,647			10a
11	Activities	110,796	7,009		117,805		117,805		117,805			11
12	Social Services	138,425	113,856	4,897	257,178		257,178		257,178			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,618,076	334,454	179,495	3,132,025		3,132,025		3,132,025			16
	C. General Administration											
17	Administrative	30,039		720,298	750,337		750,337	(394,554)	355,783			17
18	Directors Fees											18
19	Professional Services			127,277	127,277		127,277	12,505	139,782			19
20	Dues, Fees, Subscriptions & Promotions			12,257	12,257		12,257	2,532	14,789			20
21	Clerical & General Office Expenses	46,553		204,757	251,310		251,310	106,124	357,434			21
22	Employee Benefits & Payroll Taxes			427,267	427,267		427,267	56,078	483,345			22
23	Inservice Training & Education											23
24	Travel and Seminar			525	525		525	1,032	1,557			24
25	Other Admin. Staff Transportation			838	838		838	162	1,000			25
26	Insurance-Prop.Liab.Malpractice			9,486	9,486		9,486	385,740	395,226			26
27	Other (specify):*											27
28	TOTAL General Administration	76,592		1,502,705	1,579,297		1,579,297	169,619	1,748,916			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,444,605	857,229	1,978,450	6,280,284		6,280,284	208,705	6,488,989			29

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

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

Facility Name & ID Number Chicago Ridge Nursing Center #0045815 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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			30,861	30,861		30,861	485,866	516,727			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			128	128		128	427,147	427,275			32
33	Real Estate Taxes							599,298	599,298			33
34	Rent-Facility & Grounds			1,860,000	1,860,000		1,860,000	(1,860,000)				34
35	Rent-Equipment & Vehicles			1,691	1,691		1,691	300	1,991			35
36	Other (specify):*											36
37	TOTAL Ownership			1,892,680	1,892,680		1,892,680	(347,389)	1,545,291			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		7	346,077	346,084		346,084		346,084			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			583,591	583,591		583,591		583,591			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		7	929,668	929,675		929,675		929,675			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,444,605	857,236	4,800,798	9,102,639		9,102,639	(138,684)	8,963,955			45

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	31,428	30		9
10	Interest and Other Investment Income	(4,413)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(499)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(500)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,814)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(162,421)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Attached Schedule	(1,168)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (139,387)		$	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)	703		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ 703		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (138,684)		37

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

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

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

Chicago Ridge Nursing Center

ID# 0045815

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sales Taxes (Management Company)	$ (391)	2	1
2	Penalties (Management Company)	(53)	21	2
3	Entertainment (Management Company)	(724)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,168)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(890)	0	391	0	0	0	0	0	0	0	0	(499)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	3,485	0	0	0	0	0	0	0	0	0	3,485	5
6	Maintenance	0	2,378	33,557	0	0	0	0	0	0	0	0	35,935	6
7	Other (specify):*	0	0	165	0	0	0	0	0	0	0	0	165	7
8	**TOTAL General Services**	(890)	5,863	34,113	0	0	0	0	0	0	0	0	39,086	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(394,554)	0	0	0	0	0	0	0	0	(394,554)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,814)	5,054	1,244	8,021	0	0	0	0	0	0	0	12,505	19
20	Fees, Subscriptions & Promotions	0	2,317	215	0	0	0	0	0	0	0	0	2,532	20
21	Clerical & General Office Expenses	(163,698)	2,562	266,908	352	0	0	0	0	0	0	0	106,124	21
22	Employee Benefits & Payroll Taxes	0	0	56,078	0	0	0	0	0	0	0	0	56,078	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,032	0	0	0	0	0	0	0	0	1,032	24
25	Other Admin. Staff Transportation	0	132	30	0	0	0	0	0	0	0	0	162	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,434	383,306	0	0	0	0	0	0	0	385,740	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(165,512)	10,065	(66,613)	391,679	0	0	0	0	0	0	0	169,619	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(166,402)	15,928	(32,500)	391,679	0	0	0	0	0	0	0	208,705	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Chicago Ridge Nursing Center **#** 0045815 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	31,428	323	0	454,115	0	0	0	0	0	0	0	485,866	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,413)	0	(2)	431,562	0	0	0	0	0	0	0	427,147	32
33	Real Estate Taxes	0	0	0	599,298	0	0	0	0	0	0	0	599,298	33
34	Rent-Facility & Grounds	0	0	0	(1,860,000)	0	0	0	0	0	0	0	(1,860,000)	34
35	Rent-Equipment & Vehicles	0	300	0	0	0	0	0	0	0	0	0	300	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	27,015	623	(2)	(375,025)	0	0	0	0	0	0	0	(347,389)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(139,387)	16,551	(32,502)	16,654	0	0	0	0	0	0	0	(138,684)	45

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Marvin Mermelstein	30.20	RREM, Inc. d/b/a Winston Manor Nursing Home	Chicago	Nivram Mngt, Inc.	Lincolnwood	Management
Joseph Mermelstein	5.20	Balmoral Home	Chicago	MB of Chicago Ridge	Lincolnwood	Lessor
Barry Taerbaum	25.00	Central Home	Chicago			
Marvin Mermelstein Family Trust	19.80					
Joseph Mermelstein Family Trust	19.80					

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional Fees	$	Nivram Management, Inc.	100.00%	$ 5,054	$ 5,054	1
2	V	20	Advertising		Nivram Management, Inc.	100.00%	234	234	2
3	V	25	Auto Expense		Nivram Management, Inc.	100.00%	132	132	3
4	V	21	Bank Charges		Nivram Management, Inc.	100.00%	116	116	4
5	V	5	Utilities		Nivram Management, Inc.	100.00%	3,485	3,485	5
6	V	6	Repairs & Maintenance		Nivram Management, Inc.	100.00%	2,378	2,378	6
7	V	21	Postage & Delivery		Nivram Management, Inc.	100.00%	1,025	1,025	7
8	V	30	Depreciation		Nivram Management, Inc.	100.00%	323	323	8
9	V	20	Dues & Subscriptions		Nivram Management, Inc.	100.00%	2,083	2,083	9
10	V	21	Meals & Entertainment		Nivram Management, Inc.	100.00%	724	724	10
11	V	35	Equipment Rental		Nivram Management, Inc.	100.00%	300	300	11
12	V	21	Furnishing Supplies		Nivram Management, Inc.	100.00%	687	687	12
13	V	21	Housekeeping Supplies		Nivram Management, Inc.	100.00%	10	10	13
14	Total			$			$ 16,551	$ * 16,551	14

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	26	Insurance	$	Nivram Management, Inc.	100.00%	$ 2,434	$ 2,434	15
16	V	20	Marketing		Nivram Management, Inc.	100.00%	53	53	16
17	V	21	Office Expense		Nivram Management, Inc.	100.00%	15,626	15,626	17
18	V	22	Health Insurance		Nivram Management, Inc.	100.00%	17,010	17,010	18
19	V	21	Miscellaneous		Nivram Management, Inc.	100.00%	1,158	1,158	19
20	V	21	Penalties		Nivram Management, Inc.	100.00%	53	53	20
21	V	34	Rent Expense		Nivram Management, Inc.	100.00%	15,949	15,949	21
22	V	2	Sales Taxes		Nivram Management, Inc.	100.00%	391	391	22
23	V	7	Scavenger		Nivram Management, Inc.	100.00%	165	165	23
24	V	24	Seminars		Nivram Management, Inc.	100.00%	1,032	1,032	24
25	V	22	Payroll Taxes		Nivram Management, Inc.	100.00%	39,068	39,068	25
26	V	21	Telephone		Nivram Management, Inc.	100.00%	1,936	1,936	26
27	V	25	Travel		Nivram Management, Inc.	100.00%	30	30	27
28	V	20	Licenses & Permits		Nivram Management, Inc.	100.00%	162	162	28
29	V	19	Outside Labor		Nivram Management, Inc.	100.00%	1,244	1,244	29
30	V	17	Management Fees	720,298	Nivram Management, Inc.	100.00%		(720,298)	30
31	V	6	Plant Supervisor Salary		Nivram Management, Inc.	100.00%	33,557	33,557	31
32	V	17	Asst. Supervisor Salary		Nivram Management, Inc.	100.00%	50,335	50,335	32
33	V	21	Office Manager Salary		Nivram Management, Inc.	100.00%	28,640	28,640	33
34	V	17	Administrative Salary		Nivram Management, Inc.	100.00%	69,937	69,937	34
35	V	17	Administrator Salary		Nivram Management, Inc.	100.00%	205,472	205,472	35
36	V	21	Clerical Salary		Nivram Management, Inc.	100.00%	219,495	219,495	36
37	V	34	Rental Income	15,949	Hamlin & Arthur Partnership	100.00%		(15,949)	37
38	V	32	Interest Income	2	Hamlin & Arthur Partnership	100.00%		(2)	38
39	Total			$ 736,249			$ 703,747	$ * (32,502)	39

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Bank Fees	$	Hamlin & Arthur Partnership	100.00%	$ 102	$ 102	15
16	V	30	Depreciation Expense		Hamlin & Arthur Partnership	100.00%	5,669	5,669	16
17	V	19	Legal Fees		Hamlin & Arthur Partnership	100.00%	1,960	1,960	17
18	V	33	Real Estate Tax		Hamlin & Arthur Partnership	100.00%	10,809	10,809	18
19	V	34	Rental Income	1,860,000	BM of Chicago Ridge Real Estate, LLC	100.00%		(1,860,000)	19
20	V	32	Interest Income	383	BM of Chicago Ridge Real Estate, LLC	100.00%		(383)	20
21	V	19	Accounting Fees		BM of Chicago Ridge Real Estate, LLC	100.00%	6,061	6,061	21
22	V	33	Real Estate Tax		BM of Chicago Ridge Real Estate, LLC	100.00%	588,489	588,489	22
23	V	26	Insurance Expense		BM of Chicago Ridge Real Estate, LLC	100.00%	383,306	383,306	23
24	V	21	Other Taxes		BM of Chicago Ridge Real Estate, LLC	100.00%	250	250	24
25	V	32	Interest Expense		BM of Chicago Ridge Real Estate, LLC	100.00%	431,945	431,945	25
26	V	30	Depreciation Expense		BM of Chicago Ridge Real Estate, LLC	100.00%	448,446	448,446	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,860,383			$ 1,877,037	$ * 16,654	39

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES

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

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Henry Mermelstein	Administrator	Administrator	0.00	150,000	10	25.00	Salary	$ 50,000	17-7	1
2	Marvin Mermelstein	Plant Supervisor	Support	30.20	92,668	5	26.59	Salary	33,557	6-7	2
3	Doreen Mermelstein	Office Manager	Administrator	0.00	85,920	10	25.00	Salary	28,640	21-7	3
4	Marvin Mermelstein	Asst. Administrator	Administrator	See above	139,002	7	26.58	Salary	50,335	17-7	4
5	Joseph Mermelstein	Owner	Administrator	5.20	55,063	3	26.58	Salary	19,937	17-7	5
6	Barry Taerbaum	Administrator	Administrator	25.00	154,220	18	44.00	Salary	51,406	17-7	6
7	Marvin Mermelstein Family		N/A	19.80							7
8	Joseph Mermelstein Family Trust		N/A	19.80							8
9	Daniel Mermelstein	Clerical	Support	0.00	2,937	1.93	27.00	Salary	1,063	21-7	9
10	Gavriel Mermelstein	Clerical	Support	0.00	2,937	1.93	27.00	Salary	1,063	21-7	10
11	Joshua Mermelstein	Clerical	Support	0.00	6,938	3.22	27.00	Salary	2,512	21-7	11
12											12
13								TOTAL	$ 238,513		13

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

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Fees	Resident Beds	869	4	$ 19,014	$	231	$ 5,054	1
2	20	Advertising	Resident Beds	869	4	881		231	234	2
3	25	Auto Expense	Resident Beds	869	4	496		231	132	3
4	21	Bank Charges	Resident Beds	869	4	438		231	116	4
5	5	Utilities	Resident Beds	869	4	13,112		231	3,485	5
6	6	Repairs & Maintenance	Resident Beds	869	4	8,945		231	2,378	6
7	21	Postage & Delivery	Resident Beds	869	4	3,855		231	1,025	7
8	30	Depreciation	Resident Beds	869	4	1,215		231	323	8
9	20	Dues & Subscriptions	Resident Beds	869	4	7,837		231	2,083	9
10	21	Meals & Entertainment	Resident Beds	869	4	2,723		231	724	10
11	35	Equipment Rental	Resident Beds	869	4	1,130		231	300	11
12	21	Furnishing Supplies	Resident Beds	869	4	2,583		231	687	12
13	21	Housekeeping Supplies	Resident Beds	869	4	37		231	10	13
14	26	Insurance	Resident Beds	869	4	9,158		231	2,434	14
15	20	Marketing	Resident Beds	869	4	200		231	53	15
16	21	Office Expense	Resident Beds	869	4	58,782		231	15,626	16
17	22	Health Insurance	Resident Beds	869	4	63,991		231	17,010	17
18	21	Miscellaneous	Resident Beds	869	4	4,358		231	1,158	18
19	21	Penalties	Resident Beds	869	4	201		231	53	19
20	34	Rent Expense	Resident Beds	869	4	60,000		231	15,949	20
21	2	Sales Taxes	Resident Beds	869	4	1,472		231	391	21
22	7	Scavenger	Resident Beds	869	4	619		231	165	22
23	24	Seminars	Resident Beds	869	4	3,883		231	1,032	23
24	22	Payroll Taxes	Resident Beds	869	4	146,971		231	39,068	24
25	TOTALS					$ 411,901	$		$ 109,490	25

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Telephone	Resident Beds	869	4	$ 7,282	$	231	$ 1,936	1
2	25	Travel	Resident Beds	869	4	111		231	30	2
3	20	Licenses & Permits	Resident Beds	869	4	608		231	162	3
4	19	Outside Labor	Resident Beds	869	4	4,680		231	1,244	4
5	6	Plant Supervisor Salary	Direct Cost	1	1	33,557	33,557	1	33,557	5
6	17	Asst. Supervisor Salary	Direct Cost	1	1	50,335	50,335	1	50,335	6
7	21	Office Manager Salary	Direct Cost	1	1	28,640	28,640	1	28,640	7
8	17	Administrative Salary	Direct Cost	1	1	69,937	69,937	1	69,937	8
9	17	Administrator Salary	Direct Cost	1	1	205,472	205,472	1	205,472	9
10	21	Clerical Salaries	Direct Cost	1	1	219,495	219,495	1	219,495	10
11	21	Bank Fees	Resident Beds	869	4	383		231	102	11
12	30	Depreciation Expense	Resident Beds	869	4	21,326		231	5,669	12
13	19	Legal Fees	Resident Beds	869	4	7,372		231	1,960	13
14	33	Real Estate Tax	Resident Beds	869	4	40,663		231	10,809	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 689,861	$ 607,436		$ 629,348	25

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Berkley Point Capital LLC		X	Mortgage	$123,479.00	5/22/2012	$ 13,345,000	$ 12,384,831	5/22/2047	3.4300	$ 431,945	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$123,479.00		$ 13,345,000	$ 12,384,831			$ 431,945	9
	B. Non-Facility Related*											
10	Chicago RE Int. Inc.	X									(383)	10
11	Hamlin Int. Inc.	X									(2)	11
12	Home Int. Inc.		X								(4,413)	12
13	Home Int. Exp		X								128	13
14	TOTAL Non-Facility Related						$	$			$ (4,670)	14
15	TOTALS (line 9+line14)						$ 13,345,000	$ 12,384,831			$ 427,275	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 62,158 Line # 26

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

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

Facility Name & ID Number Chicago Ridge Nursing Center **#** 0045815 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	590,000	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.)	$	584,298	2
3. Under or (over) accrual (line 2 minus line 1).	$	(5,702)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	605,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	599,298	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2011	499,259	8
2012	529,314	9
2013	558,693	10
2014	605,902	11
2015	620,772	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	$	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.**

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Chicago Ridge Nursing Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0045815

CONTACT PERSON REGARDING THIS REPORT Sanford B. Alper

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

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	24-18-101-025-0000	Nursing Home	$ 415,136.89	$ 415,136.89
2.	24-18-101-039-0000	Nursing Home	$ 158,352.20	$ 158,352.20
3.	10-35-325-029-0000	Management Company	$ 4,426.35	$ 1,011.90
4.	10-35-325-015-0000	Management Company	$ 42,856.70	$ 9,797.37
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 620,772.14	$ 584,298.36

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

N/A

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	231		2007		$ 9,936,943	$ 249,034	20-40	$ 255,500	$ 6,466	$ 2,405,962	4
5					(258,650)						5
6											6
7											7
8											8
	Improvement Type**										
9	Carpet			2002	2,240	81	27.5	236	155	1,148	9
10	Washer & Dryer			2002	29,304		27.5			29,304	10
11	Phone System			2002	10,667	388	27.5	1,651	1,263	7,971	11
12	A/C System			2002	11,200	408	27.5	1,733	1,325	8,369	12
13	Electrical Improvements			2002	3,000	109	27.5	464	355	2,242	13
14	Light Fixtures			2002	10,192	371	27.5	1,577	1,206	7,619	14
15	Water Heater			2003	16,500		5			16,500	15
16	Bathroom Improvement			2005	634	23	27.5	80	57	376	16
17	Fire Smoke Dampers			2005	3,475	127	27.5	458	331	2,168	17
18	Boiler			2005	11,960		5			11,960	18
19	Locks			2006	4,374	159	27.5	491	332	2,267	19
20	Fire Alarm System			2006	98,711	3,589	27.5	11,087	7,498	51,189	20
21	AC Chiller Unit			2006	81,000	2,945	27.5	9,749	6,804	45,513	21
22	Furnace			2007	13,500	491	27.5	1,492	1,001	6,870	22
23	Temp Reset Control for Boiler			2007	2,750	100	27.5	302	202	1,386	23
24	Electrical Disconnect for Chiller Unit			2007	8,000	291	27.5	877	586	4,032	24
25	Add'l amount for '06 AC Chiller Unit			2007	8,000	291	27.5	870	579	3,994	25
26	Hot Water Storage Unit			2007	22,000	800	27.5	2,353	1,553	10,772	26
27	Control System for New Chiller			2007	1,191	43	27.5	129	86	592	27
28	Grab Bars			2007	4,941	180	27.5	528	348	2,419	28
29	Boiler Riin Change-Over Values			2007	8,380	305	27.5	889	584	4,064	29
30	Water Cooler, Attached to Building			2007	1,087	40	27.5	119	79	548	30
31	Carpeting			2007	3,138	114	27.5	319	205	1,445	31
32	Exhaust Fans			2009	7,098	258	27.5	601	343	2,622	32
33	Sprinkler System			2010	239,314	5,983	27.5	5,983		25,925	33
34	Boiler			2010	47,900	1,198	27.5	1,198		4,870	34
35	Electrical Breakers			2010	7,000	175	27.5	175		757	35
36	Fire Alarm			2011	8,982	225	27.5	225		1,275	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	Therapy Room - Flooring, Cabinets, Countertops	2011	$ 2,635	$ 96	27.5	$ 166	$ 70	$ 666	37
38	Water Heater	2011	8,170	817	10	817		4,902	38
39	Sprinkler System	2011	4,000	100	27.5	100		508	39
40	Sprinkler System	2012	6,370	159	27.5	159		736	40
41	Laminate Flooring	2012	4,768	173	27.5	173		911	41
42	Stairway Exit Doors	2012	9,097	331	27.5	331		1,353	42
43	Water Pump	2013	2,625	96	27.5	96		391	43
44	Power Conditioner	2013	5,600	140	27.5	140		525	44
45	Elevator	2013	147,995	3,700	27.5	3,700		13,567	45
46	Roof Replacement	2013	152,325	3,808	27.5	3,808		12,693	46
47	Parking Lot Repavement	2013	7,100	178	27.5	178		578	47
48	Smoking Shelter	2013	4,053	101	27.5	101		320	48
49	Wiring Upgrade	2014	6,378	232	27.5	232		618	49
50	Water Pump	2014	4,100	149	27.5	149		199	50
51	Water Heater	2014	8,373	837	27.5	837		1,167	51
52	Wiring and Hardware Installation for Cameras	2015	5,000	106	27.5	106		212	52
53	Corner Guards, Droor Coverings, Resurfacing, Panels,	2015	119,999	3,000	27.5	3,000		6,000	53
54	& installation of nursing station								54
55	Flooring Upgrades	2016	47,000	783	27.5	783		783	55
56	New Generator	2016	12,250	334	27.5	334		334	56
57	Main Sewer - Section Replacement	2016	5,247	95	27.5	95		95	57
58								95	58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 10,907,916	$ 282,963		$ 314,391	$ 31,428	$ 2,710,812	70

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 86,575	$ 18,061	$ 18,061	$	5	$ 68,969	71
72	Current Year Purchases	24,741	2,369	2,369			2,369	72
73	Fully Depreciated Assets	115,017					115,017	73
74	Management & Real Estate Co.	1,776,684	178,209	181,906	3,697			74
75	TOTALS	$ 2,003,017	$ 198,639	$ 202,336	$ 3,697		$ 186,355	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 13,345,933	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 481,602	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 516,727	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 35,125	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,897,167	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

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

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

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

10. Effective dates of current rental agreement:
Beginning 09/01/2008
Ending 12/31/2041

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

	Fiscal Year Ending	Annual Rent
12.	12/31/2017	$ 1,860,000
13.	12/31/2018	$ 1,860,000
14.	12/31/2019	$ 1,860,000

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 1,991 Description: Copier - $1,691; Management Company - $300
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			346,077			346,077	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				7		7	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$ 346,077	$ 7		$ 346,084	14

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

STATE OF ILLINOIS

Facility Name & ID Number Chicago Ridge Nursing Center **#** 0045815 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2016 **(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	$ 659,852	$ 785,695	1
2	Cash-Patient Deposits	87,336	87,336	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,668,631	2,668,631	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,576	176,435	6
7	Other Prepaid Expenses	695	695	7
8	Accounts Receivable (owners or related parties)	71,836	16,536	8
9	Other(specify): Attached Schedule	35,791	901,362	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,528,717	$ 4,636,690	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		435,000	13
14	Buildings, at Historical Cost		9,806,665	14
15	Leasehold Improvements, at Historical Cost	357,679	1,043,488	15
16	Equipment, at Historical Cost	284,097	2,060,781	16
17	Accumulated Depreciation (book methods)	(364,762)	(4,464,576)	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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 277,014	$ 8,881,358	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,805,731	$ 13,518,048	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 229,324	$ 242,047	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	135,655	135,655	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	137,248	137,248	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		605,000	32
33	Accrued Interest Payable		35,400	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Attached Schedule	6,319,606	6,338,038	36
37	Due to Related Party	4,224	4,224	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,826,057	$ 7,497,612	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,384,831	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 12,384,831	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,826,057	$ 19,882,443	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,020,326)	$ (6,364,395)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,805,731	$ 13,518,048	48

***(See instructions.)**

Facility Name & ID Number Chicago Ridge Nursing Center **#** 0045815 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,643,840)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,643,840)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,823,514	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(2,200,000)	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)**	$ 623,514	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)**	$ (3,020,326)	24 *

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,830,656	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,830,656	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	68,532	6
7	Oxygen	6,960	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 75,492	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,413	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,413	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Income	850	28
28a	Miscellaneous Income	14,742	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 15,592	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,926,153	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,568,962	31
32	Health Care	3,132,025	32
33	General Administration	1,579,043	33
	B. Capital Expense		
34	Ownership	1,892,934	34
	C. Ancillary Expense		
35	Special Cost Centers	346,084	35
36	Provider Participation Fee	583,591	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,102,639	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,823,514	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,823,514	43

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

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

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

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

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,434	2,570	$ 94,115	$ 36.62	1
2	Assistant Director of Nursing					2
3	Registered Nurses	42,709	43,836	1,240,373	28.30	3
4	Licensed Practical Nurses	4,432	4,432	99,874	22.53	4
5	CNAs & Orderlies	57,865	59,967	695,852	11.60	5
6	CNA Trainees					6
7	Licensed Therapist	1,951	2,079	52,647	25.32	7
8	Rehab/Therapy Aides	1,941	2,171	32,989	15.20	8
9	Activity Director	2,076	2,108	36,167	17.16	9
10	Activity Assistants	6,847	7,241	74,629	10.31	10
11	Social Service Workers	7,572	7,910	138,425	17.50	11
12	Dietician					12
13	Food Service Supervisor	2,546	2,681	38,488	14.36	13
14	Head Cook					14
15	Cook Helpers/Assistants	28,043	30,369	323,198	10.64	15
16	Dishwashers					16
17	Maintenance Workers	2,610	2,706	30,751	11.36	17
18	Housekeepers	22,304	23,649	249,316	10.54	18
19	Laundry	9,453	10,294	108,184	10.51	19
20	Administrator					20
21	Assistant Administrator	1,760	1,760	30,039	17.07	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,177	4,335	46,553	10.74	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,980	2,116	23,200	10.96	31
32	Other Health C: MDS	3,906	3,968	129,805	32.71	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	204,606	214,192	$ 3,444,605 *	$ 16.08	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 56,779	1-3	35
36	Medical Director	O			36
37	Medical Records Consultant	N			37
38	Nurse Consultant	T			38
39	Pharmacist Consultant	H			39
40	Physical Therapy Consultant	L			40
41	Occupational Therapy Consultant	Y			41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	F			43
44	Activity Consultant	E			44
45	Social Service Consultant	E	4,897	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 61,676		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 174,598	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$ 174,598		53

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rafael Nudell	Assistant Admin	0.00%	$ 30,039
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 30,039

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
See Attached Schedule		$ 127,277
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 127,277

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 59,019
Unemployment Compensation Insurance	26,887
FICA Taxes	257,622
Employee Health Insurance	81,989
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Dental Insurance	1,750
Allocation from Management Company	56,078
TOTAL (agree to Schedule V, line 22, col.8)	$ 483,345

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	62
Health Care Worker Background Check	
(Indicate # of checks performed 74)	2,186
Patient Background Checks 210	2,100
Dues & Subscriptions	759
Licenses & Permits	7,150
Allocation from Management Company	2,532
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,789

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	525
Allocation from Management Company	1,032
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,557

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

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

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

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

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

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **N/A**
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. $ **583,591**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

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

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

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

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

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

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

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