		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.

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

I. IDPH License ID Number: 0052431

Facility Name: Norridge Gardens

Address: 7001 West Cullom (Number) Norridge (City) 60706 (Zip Code)

County: Cook

Telephone Number: (708) 457-0700 **Fax #** (708) 457-8852

HFS ID Number:

Date of Initial License for Current Owners: 8/1/2014

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: Larry Templin **Telephone Number:** (630) 361-2868
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 1/1/16 to 12/31/16 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) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ( )

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 _____

	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	292	Skilled (SNF)	292	106,872	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	292	TOTALS	292	106,872	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			20,148	20,148	8
9	SNF/PED					9
10	ICF	59,255	11,745		71,000	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	59,255	11,745	20,148	91,148	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.29%

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] Non-allowable costs have been eliminated in Schedule V, Column 7

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 8/1/2013

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/1/2013 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 213 and days of care provided 18,290

Medicare Intermediary CGS Administrators, LLC

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	806,848	29,355	20,545	856,748		856,748		856,748			1
2	Food Purchase		776,893		776,893		776,893		776,893			2
3	Housekeeping	1,214	62,921	358,460	422,595		422,595		422,595			3
4	Laundry		45,226	276,275	321,501		321,501		321,501			4
5	Heat and Other Utilities			255,578	255,578		255,578	975	256,553			5
6	Maintenance	122,494		113,927	236,421		236,421	3,596	240,017			6
7	Other (specify):* Waste Removal			53,302	53,302		53,302		53,302			7
8	TOTAL General Services	930,556	914,395	1,078,087	2,923,038		2,923,038	4,571	2,927,609			8
	B. Health Care and Programs											
9	Medical Director			50,000	50,000		50,000		50,000			9
10	Nursing and Medical Records	6,358,606	744,519	54,481	7,157,606		7,157,606	138,420	7,296,026			10
10a	Therapy	511,013	(3,798)	24,552	531,767		531,767	(453)	531,314			10a
11	Activities	305,187		31,665	336,852		336,852		336,852			11
12	Social Services	251,038		14,865	265,903		265,903		265,903			12
13	CNA Training	13,109			13,109		13,109		13,109			13
14	Program Transportation			11,126	11,126		11,126		11,126			14
15	Other (specify):*							25,300	25,300			15
16	TOTAL Health Care and Programs	7,438,953	740,721	186,689	8,366,363		8,366,363	163,267	8,529,630			16
	C. General Administration											
17	Administrative	274,872		1,415,324	1,690,196		1,690,196	(1,235,929)	454,267			17
18	Directors Fees											18
19	Professional Services			607,962	607,962		607,962	3,456	611,418			19
20	Dues, Fees, Subscriptions & Promotions			78,323	78,323		78,323	(1,885)	76,438			20
21	Clerical & General Office Expenses	286,207	81,851	107,872	475,930		475,930	224,195	700,125			21
22	Employee Benefits & Payroll Taxes			1,721,368	1,721,368		1,721,368		1,721,368			22
23	Inservice Training & Education											23
24	Travel and Seminar			18,907	18,907		18,907	1,141	20,048			24
25	Other Admin. Staff Transportation			21,168	21,168		21,168	4,999	26,167			25
26	Insurance-Prop.Liab.Malpractice			292,133	292,133		292,133	5,117	297,250			26
27	Other (specify):*							62,964	62,964			27
28	TOTAL General Administration	561,079	81,851	4,263,057	4,905,987		4,905,987	(935,942)	3,970,045			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,930,588	1,736,967	5,527,833	16,195,388		16,195,388	(768,104)	15,427,284			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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 Norridge Gardens #0052431 Report Period Beginning: 1/1/16 Ending: 12/31/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			153,300	153,300		153,300	(132,625)	20,675			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			174,890	174,890		174,890	14,976	189,866			32
33	Real Estate Taxes			978,640	978,640		978,640		978,640			33
34	Rent-Facility & Grounds			3,538,318	3,538,318		3,538,318	34,135	3,572,453			34
35	Rent-Equipment & Vehicles			65,694	65,694		65,694		65,694			35
36	Other (specify):*											36
37	**TOTAL Ownership**			4,910,842	4,910,842		4,910,842	(83,514)	4,827,328			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		825,714	2,302,710	3,128,424		3,128,424	(266,623)	2,861,801			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			602,568	602,568		602,568		602,568			42
43	Other (specify):* Nonallowable Exp	304,207	19,785	371,774	695,766		695,766	(695,766)				43
44	**TOTAL Special Cost Centers**	304,207	845,499	3,277,052	4,426,758		4,426,758	(962,389)	3,464,369			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	9,234,795	2,582,466	13,715,727	25,532,988		25,532,988	(1,814,007)	23,718,981			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	(4,547)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(132,625)	30		9
10	Interest and Other Investment Income	(718)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(230)	20		17
18	Fines and Penalties	(3,137)	43		18
19	Entertainment				19
20	Contributions	(27,685)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(29,226)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(250,000)	43		24
25	Fund Raising, Advertising and Promotional	(4,166)	43		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 See Page 5A	(411,022)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (863,356)		$	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)	(950,651)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (950,651)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,814,007)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' PREPARATION REPORT

Norridge Gardens

ID# 0052431

Report Period Beginning: 1/1/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	(3,215)	21	1
2	Marketing Salary	(304,207)	43	2
3	Marketing Expense	(101,996)	43	3
4	Theft & Damage Loss	(28)	43	4
5	Capitalize Repairs	(7,766)	6	5
6	PAC Dues	(4,823)	20	6
7	Additional Repairs & Maintenance	11,013	6	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**	(411,022)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Norridge Gardens # 0052431 **Report Period Beginning:** 1/1/16 **Ending:** 12/31/16

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	0	975	0	0	0	0	0	0	0	0	975	5
6	Maintenance	3,247	0	349	0	0	0	0	0	0	0	0	3,596	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	3,247	0	1,324	0	0	0	0	0	0	0	0	4,571	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	154,718	(16,298)	0	0	0	0	0	0	0	138,420	10
10a	Therapy	0	0	0	0	(453)	0	0	0	0	0	0	(453)	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	25,300	0	0	0	0	0	0	0	0	25,300	15
16	**TOTAL Health Care and Programs**	0	0	180,018	(16,298)	(453)	0	0	0	0	0	0	163,267	16
	C. General Administration													
17	Administrative	0	0	(1,235,929)	0	0	0	0	0	0	0	0	(1,235,929)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(29,226)	0	19,029	0	13,653	0	0	0	0	0	0	3,456	19
20	Fees, Subscriptions & Promotions	(5,053)	0	2,366	0	802	0	0	0	0	0	0	(1,885)	20
21	Clerical & General Office Expenses	(3,215)	0	223,844	0	3,566	0	0	0	0	0	0	224,195	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,141	0	0	0	0	0	0	0	0	1,141	24
25	Other Admin. Staff Transportation	0	0	1,660	0	3,339	0	0	0	0	0	0	4,999	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	5,117	0	0	0	0	0	0	5,117	26
27	Other (specify):*	0	0	62,964	0	0	0	0	0	0	0	0	62,964	27
28	**TOTAL General Administration**	(37,494)	0	(924,925)	0	26,477	0	0	0	0	0	0	(935,942)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(34,247)	0	(743,583)	(16,298)	26,024	0	0	0	0	0	0	(768,104)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Norridge Gardens # 0052431 **Report Period Beginning:** 1/1/16 **Ending:** 12/31/16

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	(132,625)	0	0	0	0	0	0	0	0	0	0	(132,625)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(718)	0	0	0	15,694	0	0	0	0	0	0	14,976	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	34,135	0	0	0	0	0	0	0	0	34,135	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(133,343)	0	34,135	0	15,694	0	0	0	0	0	0	(83,514)	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	(266,623)	0	0	0	0	0	0	(266,623)	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):*	(695,766)	0	0	0	0	0	0	0	0	0	0	(695,766)	43
44	**TOTAL Special Cost Centers**	(695,766)	0	0	0	(266,623)	0	0	0	0	0	0	(962,389)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(863,356)	0	(709,448)	(16,298)	(224,905)	0	0	0	0	0	0	(1,814,007)	45

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/16 Ending: 12/31/16

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			$			$	$	1
2	V		See Page 6A						2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	Heat and Other Utilities	$	Premier Healthcare Management, LLC	100.00%	$ 975	$ 975	15
16	V	6	Maintenance		Premier Healthcare Management, LLC	100.00%	349	349	16
17	V	10	Nursing and Medical Records		Premier Healthcare Management, LLC	100.00%	154,718	154,718	17
18	V	15	Emp Benefit Alloc-Healthcare		Premier Healthcare Management, LLC	100.00%	25,300	25,300	18
19	V	17	Administrative	1,415,324	Premier Healthcare Management, LLC	100.00%	179,395	(1,235,929)	19
20	V	19	Professional Services		Premier Healthcare Management, LLC	100.00%	19,029	19,029	20
21	V	20	Dues, Fees, Subs & Promo		Premier Healthcare Management, LLC	100.00%	2,366	2,366	21
22	V	21	Clerical & Gen Office Expenses		Premier Healthcare Management, LLC	100.00%	223,844	223,844	22
23	V	24	Travel and Seminar		Premier Healthcare Management, LLC	100.00%	1,141	1,141	23
24	V	25	Other Admin. Staff Trans		Premier Healthcare Management, LLC	100.00%	1,660	1,660	24
25	V	27	Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	62,964	62,964	25
26	V	34	Rent-Facility & Grounds		Premier Healthcare Management, LLC	100.00%	34,135	34,135	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			$ 1,415,324			$ 705,876	$ * (709,448)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	10	Nursing and Medical Records	$ 25,697	Premier Healthcare Supplies, LLC	100.00%	$ 9,399	$ (16,298)	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			$ 25,697			$ 9,399	$ * (16,298)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	10A	Therapy	$ 453	REX Therapeutics	100.00%	$	$ (453)	15
16	V	19	Professional Services		REX Therapeutics	100.00%	13,653	13,653	16
17	V	20	Fees and Subscriptions		REX Therapeutics	100.00%	802	802	17
18	V	21	Clerical & General Office Exp		REX Therapeutics	100.00%	3,566	3,566	18
19	V	25	Other Admin Staff Transp		REX Therapeutics	100.00%	3,339	3,339	19
20	V	26	Insurance-Prop.Liab.Malp		REX Therapeutics	100.00%	5,117	5,117	20
21	V	32	Interest Expense		REX Therapeutics	100.00%	15,694	15,694	21
22	V	39	Allocated Employee Benefits		REX Therapeutics	100.00%	170,861	170,861	22
23	V	39	Therapy Consultant		REX Therapeutics	100.00%	11,380	11,380	23
24	V	39	Therapy Management Wages		REX Therapeutics	100.00%	64,016	64,016	24
25	V								25
26	V								26
27	V	39	Therapy Wages		REX Therapeutics	100.00%	1,388,534	1,388,534	27
28	V	39	Contract Therapy	1,901,414	REX Therapeutics	100.00%		(1,901,414)	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			$ 1,901,867			$ 1,676,962	$ * (224,905)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	Barak Baver	25.00%	Gilman Healthcare Center	Gilman	Premier Healthcare	Skokie	Management Co.	1
2	David Cheplowitz	25.00%	Courtyard Healthcare	Berwyn	Management, LLC			2
3	Erez Baver	5.00%	Winfield Woods Healthcare Center	Winfield	Premier Healthcare	Skokie	Medical Supply	3
4	Netzach Investments	45.00%	Pershing Gardens Healthcare Center	Stickney	Supplies, LLC			4
5			Gardenview Manor	Danville	REX Therapeutics	Skokie	Therapy	5
6			Champaign Urbana Nursing and Rehab	Savoy				6
7			Premier Healthcare of Fort Wayne, LLC	Fort Wayne, IN				7
8			Premier Healthcare of North Vernon, LLC	North Vernon, IN				8
9			Premier Healthcare of Sheridan, LLC	Sheridan, IN				9
10			Premier Healthcare of Connersville, LLC	Connersville, IN				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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	David Cheplowitz	Shareholder	Administrative	25.00%	See Att Sch 7A	10.45	26%	Alloc Salary	$ 40,749	17-7	1
2	Barak Baver	Shareholder	Administrative	25.00%	See Att Sch 7A	10.45	26%	Alloc Salary	40,749	17-7	2
3	Sara Baver	Relative	Clerical	0	See Att Sch 7A	10.45	26%	Alloc Salary	11,545	21-7	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	$ 93,043		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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/16 Ending: 12/31/16

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: Premier Healthcare Management, LLC
Street Address: 8170 N. McCormick Blvd. Suite 137
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 674-2800
Fax Number: (847) 674-4133

	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	Heat and Other Utilities	Census Days	348,950	11	$ 3,732	$	91,148	$ 975	1
2	6	Maintenance	Census Days	348,950	11	1,338		91,148	349	2
3	10	Nursing and Medical Records	Census Days	348,950	11	592,321	592,321	91,148	154,718	3
4	15	Emp Benefit Alloc-Healthcare	Census Days	348,950	11	96,859		91,148	25,300	4
5	17	Administrative	Census Days	348,950	11	686,791	686,791	91,148	179,395	5
6	19	Professional Services	Census Days	348,950	11	72,849		91,148	19,029	6
7	20	Dues, Fees, Subs & Promo	Census Days	348,950	11	9,057		91,148	2,366	7
8	21	Clerical & Gen Office Expenses	Census Days	348,950	11	856,961	787,295	91,148	223,844	8
9	24	Travel and Seminar	Census Days	348,950	11	4,369		91,148	1,141	9
10	25	Other Admin. Staff Trans	Census Days	348,950	11	6,355		91,148	1,660	10
11	27	Emp Benefit Alloc-Gen Admin	Census Days	348,950	11	241,050		91,148	62,964	11
12	34	Rent-Facility & Grounds	Census Days	348,950	11	130,681		91,148	34,135	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					$ 2,702,363	$ 2,066,407		$ 705,876	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/16 Ending: 12/31/16

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: Premier Healthcare Supplies, LLC
Street Address: 8170 N. McCormick Blvd. Suite 137
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 674-2800
Fax Number: (847) 674-4133

	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	10	Nursing and Medical Records	Revenue	111,222	11	$ 40,679	$	25,697	$ 9,399	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					$ 40,679	$		$ 9,399	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/16 Ending: 12/31/16

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: REX Therapeutics
Street Address: 8170 N. McCormick Blvd. Suite 137
City / State / Zip Code: Skokie, IL 60076
Phone Number: (847) 674-2800
Fax Number: (847) 674-4133

	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 Services	Therapy Revenue	3,342,403	4	$ 23,994	$	1,901,867	$ 13,653	1
2	20	Fees and Subscriptions	Therapy Revenue	3,342,403	4	1,410		1,901,867	802	2
3	21	Clerical & General Office Exp	Therapy Revenue	3,342,403	4	6,268		1,901,867	3,566	3
4	25	Other Admin Staff Transp	Therapy Revenue	3,342,403	4	5,868		1,901,867	3,339	4
5	26	Insurance-Prop.Liab.Malp	Therapy Revenue	3,342,403	4	8,993		1,901,867	5,117	5
6	32	Interest Expense	Therapy Revenue	3,342,403	4	27,581		1,901,867	15,694	6
7	39	Allocated Employee Benefits	Therapy Revenue	3,342,403	4	300,276		1,901,867	170,861	7
8	39	Therapy Consultant	Therapy Revenue	3,342,403	4	20,000		1,901,867	11,380	8
9	39	Therapy Management Wages	Therapy Revenue	3,342,403	4	112,504	112,504	1,901,867	64,016	9
10										10
11										11
12	39	Therapy Wages	Direct Allocation	1,388,534	1	1,388,534	1,388,534	1,388,534	1,388,534	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					$ 1,895,428	$ 1,501,038		$ 1,676,962	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/16 Ending: 12/31/16

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	First Midwest Bank		X	Line of Credit		12/31/14		3,633,900	3/31/17		159,890	6
7												7
8												8
9	TOTAL Facility Related						$	$ 3,633,900			$ 159,890	9
	B. Non-Facility Related*											
10								Allocated from REX Therapeutics			15,694	10
11								Loan Cost Amortization			15,000	11
12								Offset Interest Income			(718)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 29,976	14
15	TOTALS (line 9+line14)						$	$ 3,633,900			$ 189,866	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* 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' PREPARATION 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 Norridge Gardens # 0052431 Report Period Beginning: 1/1/16 Ending: 12/31/16

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.**		$	(169,261)	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.)	2015	$	952,726	2
3. Under or (over) accrual (line 2 minus line 1).		$	1,121,987	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$	(143,347)	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.		$	978,640	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2011		8
2012		9
2013	927,391	10
2014	942,879	11
2015	952,726	12

Accrual based on prior year tax bill.

	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.

SEE ACCOUNTANTS' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Norridge Gardens COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0052431

CONTACT PERSON REGARDING THIS REPORT Larry Templin

TELEPHONE (630) 361-2868 FAX #:

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.	13-18-318-005-0000	Long Term Care Propety	$ 254,360.54	$ 254,360.54
2.	13-18-318-006-0000	Long Term Care Propety	$ 225,807.11	$ 225,807.11
3.	13-18-318-007-0000	Long Term Care Propety	$ 227,716.16	$ 227,716.16
4.	13-18-318-008-0000	Long Term Care Propety	$ 244,842.59	$ 244,842.59
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 952,726.40	$ 952,726.40

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 X 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 Norridge Gardens # 0052431 Report Period Beginning: 1/1/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 89,972 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 4

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

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				$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/16 Ending: 12/31/16

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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Replace Elevator Door Operator			2013	11,472		20	287	287	1,578	9
10	Replace Pumping Unit			2013	13,952		20	349	349	1,919	10
11	Boiler Repair & Rtu			2013	5,992		20	599	599	3,096	11
12	Build Wood Planters			2013	12,750		20	319	319	1,807	12
13	Sprinkler System Heads & Valves In Parking Lot Foyer & South Dock			2013	3,388		20	85	85	480	13
14	Install Awning & Sign			2013	8,944		20	224	224	1,156	14
15	Fire Sprinkler Repair			2014	2,929		20	73	73	366	15
16	Re-Doing Wiring And Computer Systems			2014	22,057		20	551	551	2,665	16
17	Repair Staircases On All 4 Floors			2014	6,600		20	165	165	715	17
18	Install Shunt Trip Breaker & Panelboard For Freight Elevator			2014	6,800		20	170	170	737	18
19	Hook Up Emergency Power & Fire Service Wiring			2014	5,010		20	125	125	522	19
20	Fire Doors			2014	3,000		20	75	75	300	20
21	Convert 2 Rms On 2Nd Floor To 2 Single Bedrms & Bathrm			2014	70,300		20	1,757	1,757	7,030	21
22	Fire Doors			2014	3,360		20	84	84	336	22
23	Water Heater Surface Ignitor			2014	3,957		20	396	396	1,913	23
24	Hot Water Pump Motor			2014	2,500		20	62	62	260	24
25	Install New Elevator Care Doors			2014	2,669		20	267	267	1,112	25
26	Install New Elevator Care Doors			2014	2,669		20	267	267	890	26
27	All Areas Carpet & Millwork Cove Base, Bathroom Tile			2014	31,551		20	789	789	3,155	27
28	Install New Elevator Care Doors			2014	2,669		20	67	67	256	28
29	Fire Alarm System			2014	4,270		20	107	107	338	29
30	Sprinkler System Repair			2014	2,523		20	63	63	210	30
31	Fire Alarm Repair			2014	3,264		20	82	82	354	31
32	Replace Packing & Repair Leaking Valves			2014	2,974		20	74	74	272	32
33	Hot Water Storage Tank Replacement With Wiring/Piping			2015	7,500		20	375	375	750	33
34	Idph Construction Application/Architects/Hvac/Electrical/Sprinkler			2015	8,496		20	425	425	850	34
35	Provide/Install New A/C Unit/Electrical Wiring For Lunch Room			2015	5,500		20	275	275	550	35
36	Kitchen Cabinets/Counter Tops For 2Nd/3Rd Floor Dining Rooms			2015	2,662		20	133			36

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

See Page 12A, Line 70 for total

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	Install Cabinets/Countertops/Plumbing For 2Nd/3Rd Floor Dining	2015	$ 3,550	$	20	$ 178	$ 178	$ 356	37
38	Structural Engineering/Calculations/Analysis For Floor Addition I	2015	7,500		20	375	375	750	38
39	Provide/Install New Circuits Quad Outlets In 2Nd/3Rd Floor Spec	2015	2,680		20	134	134	268	39
40	Design Fees For First Floor Remodeling	2015	10,000		20	500	500	1,000	40
41	Replace Relief Device/Leak & Commission Test/Re-Insulate Tank	2015	7,500		20	375	375	750	41
42	Amstadter Construction Documents Detailed Architectural Design	2015	10,000		20	500	500	1,000	42
43	First Floor Remodel/Mechanical/Electrical/Plumbing/& Fire Prote	2015	10,000		20	500	500	1,000	43
44	Design Sketches First Floor Plans/Interior Elevations/Ceiling Plan	2015	10,000		20	500	500	1,000	44
45	Remove/Install New Retro Drains/Saddle For Roof/Iso Roofing Co	2015	3,200		20	160	160	320	45
46	Amstadter Architectural Design Fees	2015	10,000		20	500	500	1,000	46
47	Test/Replace Drive In Control System Contractor For Elevator	2015	2,932		20	147	147	294	47
48	Drilling 0-25'/Patching Of Asphalt/Soil Classification/ Project Rev	2015	4,360		20	218	218	436	48
49	Fertilization/Planting Flowers/Shrub & Tree Trimming In Back P	2015	2,730		20	137	137	274	49
50	Modify Pit Ladder/Hoistway Doors/Hatch Latch Door Restrictor I	2015	7,358		20	368	368	736	50
51	Replace/Repair leaking heat pipes & boiler water lines-2nd & 3rd	2016	4,238		20	106	106	106	51
52	Repaired Heat Exchanger	2016	3,528		20	88	88	88	52
53	Repair and Paint Walls in Office, Conference Rm & Kitchen	2016	5,425		20	136	136	136	53
54	Replace Tiles in Therapy Room	2016	3,900		20	98	98	98	54
55	Install Wanderguard Signalling Device	2016	3,454		20	86	86	86	55
56	New Refrigeration System with Indoor Remote Condensing	2016	11,399		20	285	285	285	56
57	2 9500 BTU Replacement units and 2 PTAC Units	2016	5,805		20	145	145	145	57
58	Carpet/Flooring - Lobby, Business Office, Conference Rm & Ente	2016	4,472		20	112	112	112	58
59	Replace Damaged Floor Tiles in Kitchen	2016	2,650		20	66	66	66	59
60	Install New Torsion-Spring Counter Balance Assembly	2016	2,650		20	66	66	66	60
61	Six new PTAC Units	2016	8,745		20	218	218	218	61
62									62
63									63
64									64
65									65
66	Allocated from Premier Healthcare Management LLC.	2013	6,501		20	324	324	1,038	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 414,335	$		$ 14,567	$ 14,434	$ 45,245	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	$ 430,361	$	$ 4,304	$ 4,304	10	$ 102,703	71
72	Current Year Purchases	36,085		1,804	1,804	10	1,804	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 466,446	$	$ 6,108	$ 6,108		$ 104,507	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)	$ 880,781	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 20,675	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 20,675	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 149,752	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	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/16 Ending: 12/31/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: FNR Norridge

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1976	292	7/1/13	$ 3,538,318			3
4	Additions							4
5	Allocated from Management Co.				34,135			5
6								6
7	TOTAL		292		$ 3,572,453 **			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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 65,694 Description: See Attached Schedule 14A
(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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Norridge Gardens**
IDPH License ID Number: **0052431**
Fiscal Year End: **12/31/16**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Nursing Equipment	52,723
Dietary Equipment	317
Storage Site	12,654
Total - Line 16	**65,694**

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/16 Ending: 12/31/16

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? [X] YES [ ] 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 [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA 130

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)		13,109		13,109
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 13,109	$	$ 13,109
10	SUM OF line 9, col. 1 and 2 (e)	$ 13,109			

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	11
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	11

(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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(1), 39(3)	10316	hrs	$ 399,469		$ 93,702	$	10,316	$ 493,171	1
2	Licensed Speech and Language Development Therapist	39(1), 39(3)	5284	hrs	204,610		47,995		5,284	252,605	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	39(1), 39(3)	20259	hrs	784,455		184,007		20,259	968,462	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				823,079		823,079	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): Therapy Manager	39(1)	824		64,016				824	64,016	12
13	Other (specify): See Attached Scheule 16A						257,833	2,635		260,468	13
14	TOTAL				$ 1,452,550		$ 583,537	$ 825,714	36,683	$ 2,861,801	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Norridge Gardens**
IDPH License ID Number: **0052431**
Fiscal Year End: **12/31/16**

Schedule 16A

XIV. Special Services
Line 13 Other Services

Description	Schedule V Line & Column Reference	Amount
Lab & Xray	39(3)	74,548
Dental	39(3)	500
Outside MD Service-MCA	39(3)	544
Medical Supplies - MCA	39(2)	2,635
Therapy Consultant	39(3)	11,380
Employee Benefits Allocated f	39(3)	170,861
Total - Line 13		**260,468**

Facility Name & ID Number Norridge Gardens **#** 0052431 **Report Period Beginning:** 1/1/16 **Ending:** 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/16 **(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	$ 44,615	$ 44,615	1
2	Cash-Patient Deposits	3,609	3,609	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 911,639)	5,617,814	5,617,814	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,915	28,915	6
7	Other Prepaid Expenses	162,744	19,397	7
8	Accounts Receivable (owners or related parties)	6,602,900	6,602,900	8
9	Other(specify): Due from Others	225,000	225,000	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 12,685,597	$ 12,542,250	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	437,204	414,335	15
16	Equipment, at Historical Cost	509,458	466,446	16
17	Accumulated Depreciation (book methods)	(336,704)	(149,752)	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): See Attached Schedule 17A	38,914,116	38,914,116	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 39,524,074	$ 39,645,145	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 52,209,671	$ 52,187,395	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,588,284	$ 2,588,284	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,609	3,609	28
29	Short-Term Notes Payable	3,633,900	3,633,900	29
30	Accrued Salaries Payable	899,139	899,139	30
31	Accrued Taxes Payable (excluding real estate taxes)	681,300	681,300	31
32	Accrued Real Estate Taxes(Sch.IX-B)		(143,347)	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	2,222,735	2,222,735	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 10,028,967	$ 9,885,620	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Capitalized Lease Liablility	38,760,845	38,760,845	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 38,760,845	$ 38,760,845	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 48,789,812	$ 48,646,465	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,419,859	$ 3,540,930	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 52,209,671	$ 52,187,395	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name: **Norridge Gardens**
IDPH License ID Number: **0052431**
Fiscal Year End: **12/31/16**

Schedule 17A

XV. Balance Sheet

Line 23 Other Assets (specify):

Description	Operating	After Consolidation
CapEx Reserve	197,110	197,110
Building-Cap Lease	38,384,003	38,384,003
Unamortized Loan Costs	333,003	333,003
Total - Line 23	**38,914,116**	**38,914,116**

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Accrued MDS Tax	187,053	187,053
Accrued Expenses	71,044	71,044
Accrued Bed Tax	106,872	106,872
Payroll Withholdings	1,464,723	1,464,723
Security Deposits	293,979	293,979
Due to HFS	99,064	99,064
Total - Line 36	**2,222,735**	**2,222,735**

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,579,090	1
2	Restatements (describe): Bad Debt Expense		2
3	**Prior Period Adjustments - Bad Debt Expense**	(847,831)	3
4	**Prior Period Adjustments - Other Expenses**	(989,646)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,741,613	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(89,184)	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	(232,570)	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)**	$ (321,754)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,419,859	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	$ 24,970,005	1
2	Discounts and Allowances for all Levels	5	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 24,970,010	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	451,387	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 451,387	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	5,984	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	425	20
21	Other Medical Services	12,065	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 18,474	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	718	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 718	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	3,215	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,215	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 25,443,804	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,923,038	31
32	Health Care	8,366,363	32
33	General Administration	4,905,987	33
	B. Capital Expense		
34	Ownership	4,910,842	34
	C. Ancillary Expense		
35	Special Cost Centers	3,824,190	35
36	Provider Participation Fee	602,568	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 25,532,988	40
41	**Income before Income Taxes (line 30 minus line 40)****	(89,184)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (89,184)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 9,768,453	44
45	Private Pay - Net Inpatient Revenue	3,037,707	45
46	Medicare - Net Inpatient Revenue	10,852,416	46
47	Other-(specify) Insurance	822,265	47
48	Other-(specify) Hospice	489,169	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 24,970,010	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.**

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	1,480	1,728	$ 104,052	$ 60.22	1
2	Assistant Director of Nursing	7,830	8,450	325,069	38.47	2
3	Registered Nurses	50,703	54,359	1,635,320	30.08	3
4	Licensed Practical Nurses	42,883	44,332	1,228,023	27.70	4
5	CNAs & Orderlies	186,925	197,024	2,718,916	13.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	22,261	24,457	511,013	20.89	8
9	Activity Director					9
10	Activity Assistants	18,007	19,633	305,187	15.54	10
11	Social Service Workers	12,804	13,754	251,038	18.25	11
12	Dietician					12
13	Food Service Supervisor	6,170	7,042	159,341	22.63	13
14	Head Cook					14
15	Cook Helpers/Assistants	51,535	55,018	647,507	11.77	15
16	Dishwashers					16
17	Maintenance Workers	5,855	6,317	122,494	19.39	17
18	Housekeepers			1,214		18
19	Laundry					19
20	Administrator	4,920	5,528	274,872	49.72	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,766	16,121	286,207	17.75	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	9,103	10,041	139,807	13.92	31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	16,409	17,411	524,735	30.14	33
34	TOTAL (lines 1 - 33)	451,651	481,215	$ 9,234,795 *	$ 19.19	34

SEE ACCOUNTANTS' PREPARATION REPORT

* 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	437	$ 20,545	L1, C3	35
36	Medical Director	Monthly	50,000	L9, C3	36
37	Medical Records Consultant	Monthly	2,400	L10, C3	37
38	Nurse Consultant	Monthly	12,000	L10, C3	38
39	Pharmacist Consultant	Monthly	40,081	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	57	3,146	L11, C3	44
45	Social Service Consultant	145	9,394	L12, C3	45
46	Other(specify)				46
47	Rehab Mgmt	Monthly	24,000	L10a, C3	47
48					48
49	TOTAL (lines 35 - 48)	639	$ 161,566		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Norridge Gardens

Period Beginning **1/1/16**
Period End **12/31/16**

Schedule 20A

XVIII. Staffing and Salary Costs

		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator		6,376	6,936	220,528	31.79
Marketing		10,033	10,475	304,207	29.04
	TOTAL	16,409	17,411	524,735	

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Brian Gallagher	Administrator	0	$ 15,804
Michael Jacobson	Administrator	0	19,240
Safet Keljalic	Administrator	0	193,030
Marcie Wiklanski	Asst. Admin	0	46,798
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 274,872

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 1,415,324
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,415,324
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal Fees	$ 69,358
FR&R/Marcum LLP	Accounting	8,515
Plante & Moran, PLLC	Accounting Services	71,940
Richard Peelo & Associates, Inc.	Accounting Services	8,400
Emdeon Business Service	Data Processing	50
Ability Network Inc	Data Processing	7,044
ADP	Data Processing	102,001
SigmaCare	Data Processing	74,211
HDSI	Data Processing	3,256
Singer Networks, LLC	Data Processing	12,482
E-Solutions	Data Processing	2,944
See Attached Schedule 21A		247,761
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 607,962

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 162,968
Unemployment Compensation Insurance	145,112
FICA Taxes	687,171
Employee Health Insurance	627,597
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Contributions	50,544
Other Employee Benefits	47,976
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,721,368

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	31,037
Health Care Worker Background Check	
(Indicate # of checks performed 300)	12,019
Patient Background Checks 200	7,930
Dues & Subscriptions	2,984
Licenses & Permits	5,528
IL Council on LTC	9,792
Allocated from Mgmt Co. / REX Ther.	3,168
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 76,438

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	18,907
Allocated from Management Co.	1,141
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 20,048

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Norridge Gardens**
IDPH License ID Number: **0052431**
Fiscal Year End: **12/31/16**

Schedule 21A

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
LTC Consulting Services	Medical Billing Consulting	175,443
Terrill Consulting Services, Inc.	Billing Consultant	28,762
Medusind Solutions Inc.	Billing Consultant	9,424
Personnel Planners	UC Consultant	2,343
Stout Risius Ross, Inc	Financial Consultant	6,000
M & M Financial	Financial Consultant	5,000
Perfect Staffing	Employment Consultant	(874)
Change Healthcare	Data Processing	692
Dyatech, LLC	Employee Benefit Consultant	868
Cairs	Interpreting Service	253
Cohn Reznick	Accounting Services	18,850
Louise A. Simpson	Accounting Services	1,000
Total		**247,761**

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/16 Ending: 12/31/16

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. **9,792 IL Council on LTC**

(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. $ **46,447** Line **10**

(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. $ **602,568**
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.

SEE ACCOUNTANTS' PREPARATION REPORT

(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. $ **None** 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? **100% Ln 14**
d. Have vehicle usage logs been maintained? **N/A**
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? **N/A**
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