FOR BHF USE

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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: BM of Chicago Ridge, LLC d/b/a Chicago Ridge Nursing & Rehab Center

Address: 10602 Southwest Highway (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 01/01/2017 to 12/31/2017 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) Wipfli LLP, 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 BM of Chicago Ridge, LLC d/b/a Chicago Ridge Nursing & Rehab Center # 0045815 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	231	Skilled (SNF)	231	84,315	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	231	TOTALS	231	84,315	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	68,447	2,971	7,238	78,656	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	68,447	2,971	7,238	78,656	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.29%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 3,812

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: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number BM of Chicago Ridge, LLC d/b/a Chicago Ric # 0045815 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	372,118	21,857	16,125	410,100		410,100	12,500	422,600			1
2	Food Purchase		371,823		371,823		371,823	(589)	371,234			2
3	Housekeeping	352,516	29,208		381,724		381,724		381,724			3
4	Laundry	110,760	11,615		122,375		122,375		122,375			4
5	Heat and Other Utilities			210,258	210,258		210,258	3,302	213,560			5
6	Maintenance	32,253	51,077		83,330		83,330	39,578	122,908			6
7	Other (specify):*			39,644	39,644		39,644	256	39,900			7
8	TOTAL General Services	867,647	485,580	266,027	1,619,254		1,619,254	55,047	1,674,301			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,454,746	227,151	188,898	2,870,795		2,870,795		2,870,795			10
10a	Therapy	64,925			64,925		64,925		64,925			10a
11	Activities	122,011	470		122,481		122,481		122,481			11
12	Social Services	140,332	99,540	5,372	245,244		245,244		245,244			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Restorative Nurse	50,902			50,902		50,902		50,902			15
16	TOTAL Health Care and Programs	2,832,916	327,161	194,270	3,354,347		3,354,347		3,354,347			16
	C. General Administration											
17	Administrative	39,405		1,785,512	1,824,917		1,824,917	(513,872)	1,311,045			17
18	Directors Fees											18
19	Professional Services			142,546	142,546		142,546	34,772	177,318			19
20	Dues, Fees, Subscriptions & Promotions			11,087	11,087		11,087	5,362	16,449			20
21	Clerical & General Office Expenses	80,589		147,274	227,863		227,863	226,239	454,102			21
22	Employee Benefits & Payroll Taxes			560,326	560,326		560,326	77,105	637,431			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,754	1,754		1,754	815	2,569			24
25	Other Admin. Staff Transportation			902	902		902	165	1,067			25
26	Insurance-Prop.Liab.Malpractice			2,783	2,783		2,783	471,992	474,775			26
27	Other (specify):*											27
28	TOTAL General Administration	119,994		2,652,184	2,772,178		2,772,178	302,578	3,074,756			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,820,557	812,741	3,112,481	7,745,779		7,745,779	357,625	8,103,404			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: BM of Chicago Ridge, LLC d/b/a Chicago Ridge Nursing & F#0045815 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			26,767	26,767		26,767	385,396	412,163			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,987	4,987		4,987	412,175	417,162			32
33	Real Estate Taxes							591,163	591,163			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	318	2,009			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,893,445	1,893,445		1,893,445	(470,948)	1,422,497			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			281,672	281,672		281,672		281,672			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			579,477	579,477		579,477		579,477			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			861,149	861,149		861,149		861,149			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,820,557	812,741	5,867,075	10,500,373		10,500,373	(113,323)	10,387,050			45

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

Facility Name & ID Number BM of Chicago Ridge, LLC d/b/a Chicago Ridge Nursing # 0045815 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	(4,364)	30		9
10	Interest and Other Investment Income	(11,587)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(589)	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	(6,100)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals	(109,466)	21		23
24	Bad Debt				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	(295)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (132,401)		$	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)	19,078		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 19,078		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (113,323)		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

STATE OF ILLINOIS

BM of Chicago Ridge, LLC d/b/a Chicago Ridge Nursing & Rehab Center

ID# 0045815

Report Period Beginning: 01/01/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sales Taxes (Management Company)	$ (295)	2	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(295)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BM of Chicago Ridge, LLC d/b/a Chicago Ridge Nursing & I # 0045815 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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	12,500	0	0	0	0	0	0	0	0	12,500	1
2	Food Purchase	(884)	0	295	0	0	0	0	0	0	0	0	(589)	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	3,302	0	0	0	0	0	0	0	0	0	3,302	5
6	Maintenance	0	2,614	36,964	0	0	0	0	0	0	0	0	39,578	6
7	Other (specify):*	0	0	256	0	0	0	0	0	0	0	0	256	7
8	**TOTAL General Services**	(884)	5,916	50,015	0	0	0	0	0	0	0	0	55,047	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	(513,872)	0	0	0	0	0	0	0	0	(513,872)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,508	2,658	27,606	0	0	0	0	0	0	0	34,772	19
20	Fees, Subscriptions & Promotions	0	5,189	173	0	0	0	0	0	0	0	0	5,362	20
21	Clerical & General Office Expenses	(115,566)	4,184	337,306	315	0	0	0	0	0	0	0	226,239	21
22	Employee Benefits & Payroll Taxes	0	0	77,105	0	0	0	0	0	0	0	0	77,105	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	815	0	0	0	0	0	0	0	0	815	24
25	Other Admin. Staff Transportation	0	165	0	0	0	0	0	0	0	0	0	165	25
26	Insurance-Prop.Liab.Malpractice	0	1,276	0	470,716	0	0	0	0	0	0	0	471,992	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(115,566)	15,322	(95,815)	498,637	0	0	0	0	0	0	0	302,578	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(116,450)	21,238	(45,800)	498,637	0	0	0	0	0	0	0	357,625	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BM of Chicago Ridge, LLC d/b/a Chicago Ridge Nursing & # 0045815 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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	(4,364)	8,299	5,669	375,792	0	0	0	0	0	0	0	385,396	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,587)	0	(3)	423,765	0	0	0	0	0	0	0	412,175	32
33	Real Estate Taxes	0	0	7,380	583,783	0	0	0	0	0	0	0	591,163	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	318	0	0	0	0	0	0	0	0	0	318	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(15,951)	8,617	13,046	(476,660)	0	0	0	0	0	0	0	(470,948)	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)**	(132,401)	29,855	(32,754)	21,977	0	0	0	0	0	0	0	(113,323)	45

Facility Name & ID Number BM of Chicago Ridge, LLC d/b/a Chicago Ridge Nursing & Rehab Center # 0045815 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 Mgmt, Inc.	Lincolnwood	Management
Joseph Mermelstein	5.20	Balmoral Home	Chicago	BM of Chicago Ridge	Lincolnwood	Lessor
Barry Taerbaum	25.00	Central Home	Chicago			
Marvin Mermelstein Family Trust	19.80					
Joseph Memelstein 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	20	Advertising	$	Nivram Management, Inc.	100.00%	$ 3,257	$ 3,257	1
2	V	25	Auto Expense		Nivram Management, Inc.	100.00%	165	165	2
3	V	21	Bank Charges		Nivram Management, Inc.	100.00%	100	100	3
4	V	5	Utilities		Nivram Management, Inc.	100.00%	3,302	3,302	4
5	V	6	Repairs and Maintenance		Nivram Management, Inc.	100.00%	2,614	2,614	5
6	V	19	Professional Fees		Nivram Management, Inc.	100.00%	4,508	4,508	6
7	V	30	Depreciation		Nivram Management, Inc.	100.00%	8,299	8,299	7
8	V	21	Contributions		Nivram Management, Inc.	100.00%	49	49	8
9	V	20	Dues and Subscriptions		Nivram Management, Inc.	100.00%	1,932	1,932	9
10	V	35	Equipment Rental		Nivram Management, Inc.	100.00%	318	318	10
11	V	21	Miscellaneous		Nivram Management, Inc.	100.00%	1,881	1,881	11
12	V	21	Furnishing Supplies		Nivram Management, Inc.	100.00%	2,154	2,154	12
13	V	26	Insurance		Nivram Management, Inc.	100.00%	1,276	1,276	13
14	Total			$			$ 29,855	$ * 29,855	14

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

Facility Name & ID Number BM of Chicago Ridge, LLC d/b/a Chicago Ridge Nursing & Rehab Center # 0045815 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	22	Health Insurance	$	Nivram Management, Inc.	100.00%	$ 26,443	$ 26,443	15
16	V	19	Legal Fees		Nivram Management, Inc.	100.00%	2,658	2,658	16
17	V	20	Licenses and Permits		Nivram Management, Inc.	100.00%	173	173	17
18	V	21	Office Expense		Nivram Management, Inc.	100.00%	6,456	6,456	18
19	V	21	Postage		Nivram Management, Inc.	100.00%	754	754	19
20	V	34	Rent Expense		Nivram Management, Inc.	100.00%	15,949	15,949	20
21	V	2	Sales Tax		Nivram Management, Inc.	100.00%	295	295	21
22	V	7	Scavenger		Nivram Management, Inc.	100.00%	256	256	22
23	V	24	Travel & Seminars		Nivram Management, Inc.	100.00%	815	815	23
24	V	22	Payroll Taxes		Nivram Management, Inc.	100.00%	50,662	50,662	24
25	V	21	Telephone		Nivram Management, Inc.	100.00%	1,852	1,852	25
26	V	17	Management Fees	770,880	Nivram Management, Inc.	100.00%		(770,880)	26
27	V	6	Plant Supervisor Salary		Nivram Management, Inc.	100.00%	36,964	36,964	27
28	V	17	Asst. Supervisor Salary		Nivram Management, Inc.	100.00%	55,448	55,448	28
29	V	21	Office Manager Salary		Nivram Management, Inc.	100.00%	42,493	42,493	29
30	V	17	Administrative Salary		Nivram Management, Inc.	100.00%	19,937	19,937	30
31	V	1	Food Service Supervisor		Nivram Management, Inc.	100.00%	12,500	12,500	31
32	V	17	Administrator Salary		Nivram Management, Inc.	100.00%	181,623	181,623	32
33	V	21	Clerical Salary		Nivram Management, Inc.	100.00%	285,746	285,746	33
34	V	34	Rental Income	15,949	Hamlin & Arthur Partnership	100.00%		(15,949)	34
35	V	32	Interest Income	3	Hamlin & Arthur Partnership	100.00%		(3)	35
36	V	21	Bank Fees		Hamlin & Arthur Partnership	100.00%	5	5	36
37	V	30	Depreciation Expense		Hamlin & Arthur Partnership	100.00%	5,669	5,669	37
38	V	33	Real Estate Taxes		Hamlin & Arthur Partnership	100.00%	7,380	7,380	38
39	Total			$ 786,832			$ 754,078	$ * (32,754)	39

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

Facility Name & ID Number BM of Chicago Ridge, LLC d/b/a Chicago Ridge Nursing & Rehab Center # 0045815 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	34	Rental Income	$ 1,860,000	BM of Chicago Ridge Real Estate, LLC	100.00%	$	$ (1,860,000)	15
16	V	32	Interest Income	271	BM of Chicago Ridge Real Estate, LLC	100.00%		(271)	16
17	V	19	Legal Fees		BM of Chicago Ridge Real Estate, LLC	100.00%	21,606	21,606	17
18	V	19	Accounting Fees		BM of Chicago Ridge Real Estate, LLC	100.00%	6,000	6,000	18
19	V	21	Bank Fees		BM of Chicago Ridge Real Estate, LLC	100.00%	65	65	19
20	V	33	Real Estate Tax		BM of Chicago Ridge Real Estate, LLC	100.00%	583,783	583,783	20
21	V	26	Insurance Expense		BM of Chicago Ridge Real Estate, LLC	100.00%	470,716	470,716	21
22	V	21	Other Taxes		BM of Chicago Ridge Real Estate, LLC	100.00%	250	250	22
23	V	32	Interest Expense		BM of Chicago Ridge Real Estate, LLC	100.00%	424,036	424,036	23
24	V	30	Depreciation Expense		BM of Chicago Ridge Real Estate, LLC	100.00%	375,792	375,792	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,860,271			$ 1,882,248	$ * 21,977	39

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

Facility Name & ID Number BM of Chicago Ridge, LLC d/b/a Chicago Ri # 0045815 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	Marvin Mermelstein	Plant Supervisor	Support	30.20	102,094	5	26.58	Salary	$ 36,964	6-7	1
2	Doreen Mermelstein	Office Manager	Administrator	0.00	127,479	10	25.00	Salary	42,493	12-7	2
3	Marvin Mermelstein	Asst. Administrator	Administrator	See above	153,140	7	26.58	Salary	55,448	17-7	3
4	Joseph Mermelstein	Owner	Administrator	5.20	55,063	3	26.58	Salary	19,937	17-7	4
5	Barry Taerbaum	Administrator	Administrator	25.00	177,020	10	25.00	Salary	25,006	17-7	5
6	Marvin Mermelstein Family		N/A	19.80							6
7	Joseph Mermelstein Family Trust		N/A	19.80							7
8	Daniel Mermelstein	Clerical	Support	0.00	4,038	2	26.58	Salary	1,462	21-7	8
9	Gavriel Mermelstein	Clerical	Support	0.00	4,038	2	26.58	Salary	1,462	21-7	9
10	Joel Mermelstein	IT Manager	Support	0.00	76,350	11	26.58	Salary	27,643	21-7	10
11	Jeffrey Mermelstein	Clerical	Support	0.00	2,181	1	26.58	Salary	789	21-7	11
12	Joshua Mermelstein	Clerical	Support	0.00	17,180	3	26.58	Salary	6,220	21-7	12
13								TOTAL	$ 217,424		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 BM of Chicago Ridge, LLC d/b/a Chicago Ri # 0045815 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	Marvin Mermelstein	Partner	Other	30.20		5	26.58	Guaranteed Pa	$ 760,974	17-3	1
2	Barry Taerbaum	Partner	Other	25.00		10	25.00	Guaranteed Payn	253,658	17-3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 1,014,632		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 BM of Chicago Ridge, LLC d/b/a Chicago Ridge Nursing & # 0045815 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

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 Ave
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	20	Advertising	Resident Beds	869	4	$ 12,253	$	231	$ 3,257	1
2	25	Auto Expense	Resident Beds	869	4	621		231	165	2
3	21	Bank Charges	Resident Beds	869	4	377		231	100	3
4	5	Utilities	Resident Beds	869	4	12,420		231	3,302	4
5	6	Repairs and Maintenance	Resident Beds	869	4	9,834		231	2,614	5
6	19	Professional Fees	Resident Beds	869	4	16,959		231	4,508	6
7	30	Depreciation	Resident Beds	869	4	31,220		231	8,299	7
8	21	Contributions	Resident Beds	869	4	185		231	49	8
9	20	Dues and Subscriptions	Resident Beds	869	4	7,270		231	1,933	9
10	35	Equipment Rental	Resident Beds	869	4	1,195		231	318	10
11	21	Miscellaneous	Resident Beds	869	4	7,076		231	1,881	11
12	21	Furnishing Supplies	Resident Beds	869	4	8,101		231	2,153	12
13	26	Insurance	Resident Beds	869	4	4,802		231	1,276	13
14	22	Health Insurance	Resident Beds	869	4	99,475		231	26,443	14
15	19	Legal Fees	Resident Beds	869	4	10,000		231	2,658	15
16	20	Licenses and Permits	Resident Beds	869	4	650		231	173	16
17	21	Office Expense	Resident Beds	869	4	24,286		231	6,456	17
18	21	Postage	Resident Beds	869	4	2,835		231	754	18
19	34	Rent Expense	Resident Beds	869	4	60,000		231	15,949	19
20	2	Sales Tax	Resident Beds	869	4	1,111		231	295	20
21	7	Scavenger	Resident Beds	869	4	963		231	256	21
22	24	Travel & Seminars	Resident Beds	869	4	3,066		231	815	22
23	22	Payroll Taxes	Resident Beds	869	4	190,587		231	50,662	23
24	21	Telephone	Resident Beds	869	4	6,966		231	1,852	24
25	TOTALS					$ 512,252	$		$ 136,168	25

Facility Name & ID Number BM of Chicago Ridge, LLC d/b/a Chicago Ridge Nursing & # 0045815 Report Period Beginning: 01/01/2017 Ending: 2/31/2017

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 Ave
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	6	Plant Supervisor Salary	Direct Cost	1	1	$ 36,964	$ 36,964	1	$ 36,964	1
2	17	Asst. Supervisor Salary	Direct Cost	1	1	55,448	55,448	1	55,448	2
3	21	Office Manager Salary	Direct Cost	1	1	42,493	42,493	1	42,493	3
4	17	Administrative Salary	Direct Cost	1	1	19,937	19,937	1	19,937	4
5	1	Food Service Supervisor	Direct Cost	1	1	12,500	12,500	1	12,500	5
6	17	Administrator Salary	Direct Cost	1	1	181,623	181,623	1	181,623	6
7	21	Clerical Salary	Direct Cost	1	1	285,746	285,746	1	285,746	7
8	21	Bank Fees	Resident Beds	869	4	17		231	5	8
9	30	Depreciation Expense	Resident Beds	869	4	21,326		231	5,669	9
10	33	Real Estate Taxes	Resident Beds	869	4	27,764		231	7,380	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					$ 683,818	$ 634,711		$ 647,765	25

Facility Name & ID Number BM of Chicago Ridge, LLC d/b/a Chicago Ri # 0045815 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	Berkley Point Capital LLC		X	Mortgage	$157,326.00	2012	$ 13,345,000	$ 12,150,606	5/22/2047	3.4300	$ 424,036	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$157,326.00		$ 13,345,000	$ 12,150,606			$ 424,036	9
	B. Non-Facility Related*											
10	Chicago RE Int. Inc.	X									(271)	10
11	Hamlin Int. Inc.	X									(3)	11
12	Home Int. Inc.		X								(11,587)	12
13	Home Int. Exp.		X								4,987	13
14	TOTAL Non-Facility Related						$	$			$ (6,874)	14
15	TOTALS (line 9+line14)						$ 13,345,000	$ 12,150,606			$ 417,162	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 60,995 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 BM of Chicago Ridge, LLC d/b/a Chicago Ridge Nursing & Rehab Cente **#** 0045815 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 605,000	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.)		$ 592,690	2
3. Under or (over) accrual (line 2 minus line 1).		$ (12,310)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 603,473	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.		$ 591,163	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	529,314	8
	2013	558,693	9
	2014	605,902	10
	2015	620,772	11
	2016	617,594	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BM of Chicago Ridge, LLC d/b/a Chicago Ridge Nursing & F 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 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	24-18-101-025-0000	Nursing Home	$ 423,693.93	$ 423,693.93
2.	24-18-101-039-0000	Nursing Home	$ 161,616.22	$ 161,616.22
3.	10-35-325-029-0000	Management Company	$ 4,525.78	$ 1,034.63
4.	10-35-325-015-0000	Management Company	$ 27,757.84	$ 6,345.65
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 617,593.77	$ 592,690.43

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 BM of Chicago Ridge, LLC d/b/a Chicago Ridge Nursing & Rehab Center # 0045815 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 BM of Chicago Ridge, LLC d/b/a Chicago Ridge Nursing & Rehab Center # 0045815 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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		$ 9,678,293	$ 249,034	20-40	$ 249,034	$	$ 2,654,996	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Carpet			2002	2,240	81	27.5	81		1,229	9
10	Washer & Dryer			2002	29,304		27.5			29,304	10
11	Phone System			2002	10,667	387	27.5	388	1	8,359	11
12	A/C System			2002	11,200	407	27.5	407		8,776	12
13	Electrical Improvements			2002	3,000	109	27.5	109		2,351	13
14	Light Fixtures			2002	10,192	370	27.5	371	1	7,990	14
15	Water Heater			2003	16,500		5			16,500	15
16	Bathroom Improvement			2005	634	24	27.5	23	(1)	399	16
17	Fire Smoke Dampers			2005	3,475	126	27.5	126		2,294	17
18	Boiler			2005	11,960		5			11,960	18
19	AC Chiller Unit			2006	81,000	2,945	27.5	2,945		48,458	19
20	Locks			2006	4,374	159	27.5	159		2,426	20
21	Fire Alarm System			2006	98,711	3,589	27.5	3,589		54,778	21
22	Furnace			2007	13,500	491	27.5	491		7,361	22
23	Temp Reset Control for Boiler			2007	2,750	100	27.5	100		1,486	23
24	Electrical Disconnect for Chiller Unit			2007	8,000	291	27.5	291		4,323	24
25	Add'l amount for '06 AC Chiller Unit			2007	8,000	291	27.5	291		4,285	25
26	Hot Water Storage Unit			2007	22,000	800	27.5	800		11,572	26
27	Control System for New Chiller			2007	1,191	44	27.5	43	(1)	635	27
28	Grab Bars			2007	4,941	179	27.5	180	1	2,599	28
29	Boiler Riin Change-Over Values			2007	8,380	305	27.5	305		4,369	29
30	Water Cooler, Attached to Building			2007	1,087	40	27.5	40		588	30
31	Carpeting			2007	3,138	114	27.5	114		1,559	31
32	Exhaust Fans			2009	7,098	258	27.5	258		2,880	32
33	Sprinkler System			2010	239,314	5,983	27.5	8,702	2,719	34,627	33
34	Boiler			2010	47,900	1,198	27.5	1,742	544	6,612	34
35	Electrical Breakers			2010	7,000	175	27.5	255	80	1,012	35
36	Fire Alarm			2011	8,982	225	27.5	327		1,602	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 BM of Chicago Ridge, LLC d/b/a Chicago Ridge Nursing & Rehab Center # 0045815 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 96	$	$ 762	37
38	Water Heater	2011	8,170	817	10	817		5,719	38
39	Sprinkler System	2011	4,000	100	27.5	145	45	653	39
40	Sprinkler System	2012	6,370	159	27.5	232	73	968	40
41	Laminate Flooring	2012	4,768	173	27.5	173		1,084	41
42	Stairway Exit Doors	2012	9,097	330	27.5	331	1	1,684	42
43	Water Pump	2013	2,625	96	27.5	95	(1)	486	43
44	Power Conditioner	2013	5,600	140	27.5	204	64	729	44
45	Elevator	2013	147,995	3,700	27.5	5,382	1,682	18,949	45
46	Roof Replacement	2013	152,325	3,803	27.5	5,539	1,736	18,232	46
47	Parking Lot Repavement	2013	7,100	178	27.5	258	80	836	47
48	Smoking Shelter	2013	4,053	101	27.5	147	46	467	48
49	Wiring Upgrade	2014	6,378	232	27.5	232		850	49
50	Water Pump	2014	4,100	149	27.5	149		348	50
51	Water Heater	2014	8,373	837	27.5	304	(533)	1,471	51
52	Wiring and Hardware Installation for Cameras	2015	5,000	182	27.5	182		394	52
53	Corner Guards, Droor Coverings, Resurfacing, Panels,	2015	119,999	3,000	27.5	4,364	1,364	10,364	53
54	& installation of nursing station								54
55	1-3 Floor Nursing Stations; 2nd Floor Hallways/Lunch Room	2016	47,000	1,175	27.5	1,709	534	2,492	55
56	New Generator	2016	12,250	446	27.5	445	(1)	779	56
57	Main Sewer - Section Replacement	2016	5,247	191	27.5	191		286	57
58	Flooring - 1st Floor Hallways, Lunch Room, Elevators	2016	29,691	742	27.5	1,080	338	1,235	58
59	Flooring - Smoke Room	2016	6,100	152	27.5	222	70	254	59
60	2nd Floor Loft Elevations & Cove Bases	2017	33,650	421	27.5	1,224	803	1,224	60
61	Hot Water Valve	2017	5,800	36	27.5	211	175	211	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 10,983,157	$ 284,981		$ 294,903	$ 9,820	$ 3,005,807	70

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

Facility Name & ID Number BM of Chicago Ridge, LLC d/b/a Chicago Ridge Nu # 0045815 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 122,202	$ 15,290	$ 14,977	$ (313)	5	$ 84,718	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	127,399					127,399	73
74	Management & Real Estate Co.	1,753,416	102,283	102,283				74
75	TOTALS	$ 2,003,017	$ 117,573	$ 117,260	$ (313)		$ 212,117	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)	$ 13,421,174	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 402,554	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 412,163	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 9,609	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,217,924	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 BM of Chicago Ridge, LLC d/b/a Chicago Ridge Nursing & # 0045815 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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.	12/31/2018	$ 1,860,000
13.	12/31/2019	$ 1,860,000
14.	12/31/2020	$ 1,860,000

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 2,009 Description: Copier - $1,691; Management Company - $318
(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 BM of Chicago Ridge, LLC d/b/a Chicago Ridge Nursing & Rehab Center # 0045815 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 BM of Chicago Ridge, LLC d/b/a Chicago Ridge Nursing & Rehab Cente # 0045815 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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			281,672			281,672	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$ 281,672	$		$ 281,672	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 BM of Chicago Ridge, LLC d/b/a Chicago Ridge Nursing & # 0045815 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2017 **(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	$ 909,202	$ 964,002	1
2	Cash-Patient Deposits	94,672	94,672	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,183,443	1,183,443	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,362	269,273	6
7	Other Prepaid Expenses	695	695	7
8	Accounts Receivable (owners or related parties)	293,774		8
9	Other(specify): Attached Schedule		984,484	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,490,148	$ 3,496,569	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		9,678,293	14
15	Leasehold Improvements, at Historical Cost	393,470	1,247,101	15
16	Equipment, at Historical Cost	284,097	2,060,781	16
17	Accumulated Depreciation (book methods)	(391,716)	(4,867,322)	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)**	$ 285,851	$ 8,553,853	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,775,999	$ 12,050,422	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 292,543	$ 301,946	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	91,218	91,218	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	166,277	166,277	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		627,314	32
33	Accrued Interest Payable		34,730	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	29,395	29,395	35
	Other Current Liabilities(specify):			
36	Attached Schedule	6,365,934	6,365,934	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,945,367	$ 7,616,814	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,046,022	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)**	$	$ 12,046,022	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,945,367	$ 19,662,836	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,169,368)	$ (7,612,414)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,775,999	$ 12,050,422	48

***(See instructions.)**

Facility Name & ID Number BM of Chicago Ridge, LLC d/b/a Chicago Ridge Nursing & Rehab C # 0045815 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,020,513)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,020,513)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,857,314	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	(3,006,169)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,148,855)	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)**	$ (4,169,368)	24 *

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

Facility Name & ID Number BM of Chicago Ridge, LLC d/b/a Chicago Ridge Nu # 0045815 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 12,292,640	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,292,640	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	57,544	6
7	Oxygen	35,106	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 92,650	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	60,766	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	130	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 60,896	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11,587	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11,587	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Income	1,200	28
28a	Miscellaneous Income	1,970	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,170	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,460,943	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,619,254	31
32	Health Care	3,354,347	32
33	General Administration	2,772,178	33
	B. Capital Expense		
34	Ownership	1,893,445	34
	C. Ancillary Expense		
35	Special Cost Centers	281,672	35
36	Provider Participation Fee	579,477	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,500,373	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,960,570	41
42	**Income Taxes**	(103,256)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,857,314	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 BM of Chicago Ridge, LLC d/b/a Chicago Ridge Nursing & # 0045815 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	2,485	2,621	$ 99,330	$ 37.90	1
2	Assistant Director of Nursing					2
3	Registered Nurses	39,919	41,399	1,252,660	30.26	3
4	Licensed Practical Nurses	5,040	5,135	127,629	24.85	4
5	CNAs & Orderlies	56,648	59,207	779,607	13.17	5
6	CNA Trainees					6
7	Licensed Therapist	2,006	2,141	64,925	30.32	7
8	Rehab/Therapy Aides	2,082	2,218	36,168	16.31	8
9	Activity Director	2,084	2,268	37,350	16.47	9
10	Activity Assistants	7,353	7,753	84,661	10.92	10
11	Social Service Workers	7,539	7,818	140,332	17.95	11
12	Dietician					12
13	Food Service Supervisor	2,750	2,790	56,131	20.12	13
14	Head Cook					14
15	Cook Helpers/Assistants	28,144	29,750	315,987	10.62	15
16	Dishwashers					16
17	Maintenance Workers	2,552	2,688	32,253	12.00	17
18	Housekeepers	30,293	32,073	352,516	10.99	18
19	Laundry	9,655	10,275	110,760	10.78	19
20	Administrator					20
21	Assistant Administrator	1,808	1,808	39,405	21.79	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,108	6,361	80,589	12.67	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	1,995	2,130	24,119	11.32	31
32	Other Health C: Care Plan/MDS	3,931	4,071	135,233	33.22	32
33	Other(specify) Restorative Nurse	1,591	1,615	50,902	31.52	33
34	TOTAL (lines 1 - 33)	213,983	224,121	$ 3,820,557 *	$ 17.05	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	$ 16,125	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	5,372	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 21,497		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 188,898	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$ 188,898		53

Facility Name & ID Number BM of Chicago Ridge, LLC d/b/a Chicago Ridge Nurs # 0045815 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Raphael Nudell	Assistant Admin	0.00%	$ 7,236
Yehuda Weiman	Assistant Admin	0.00%	32,169
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 39,405

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		$ 142,546
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 142,546

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 68,705
Unemployment Compensation Insurance	27,995
FICA Taxes	285,124
Employee Health Insurance	176,923
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Dental Insurance	1,579
Allocation from Management Company	77,105
TOTAL (agree to Schedule V, line 22, col.8)	$ 637,431

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	50
Health Care Worker Background Check	
(Indicate # of checks performed 34)	1,392
Patient Background Checks 159	1,590
Dues & Subscriptions	1,874
Licenses & Permits	5,681
Marketing	500
Allocation from Management Company	5,362
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,449

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,754
Allocation from Management Company	815
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,569

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BM of Chicago Ridge, LLC d/b/a Chicago Ridge Nursing & Rehab Cente # 0045815 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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 politica
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 fo
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 Departmen
during this cost report period. $ **579,477**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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 fo
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? **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
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