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: 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 1/1/2017 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) 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: 1/1/2017 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 _____

	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	106,580	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	106,580	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			18,237	18,237	8
9	SNF/PED					9
10	ICF	61,913	12,396		74,309	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	61,913	12,396	18,237	92,546	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.83%

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)
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 292 and days of care provided 16,236

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: 12/31/17 Fiscal Year: 12/31/17

* 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: 1/1/2017 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	809,653	13,962	18,448	842,063		842,063		842,063			1
2	Food Purchase		775,647		775,647		775,647		775,647			2
3	Housekeeping	16,681	35,877	326,404	378,962		378,962		378,962			3
4	Laundry		28,317	252,560	280,877		280,877		280,877			4
5	Heat and Other Utilities			246,751	246,751		246,751	1,397	248,148			5
6	Maintenance	126,961		112,976	239,937		239,937	8,588	248,525			6
7	Other (specify):* Waste Removal			35,586	35,586		35,586		35,586			7
8	TOTAL General Services	953,295	853,803	992,725	2,799,823		2,799,823	9,985	2,809,808			8
	B. Health Care and Programs											
9	Medical Director			54,000	54,000		54,000		54,000			9
10	Nursing and Medical Records	6,379,163	690,333	74,710	7,144,206		7,144,206	155,895	7,300,101			10
10a	Therapy	450,666	411	27,213	478,290		478,290	(3,213)	475,077			10a
11	Activities	311,146		34,718	345,864		345,864		345,864			11
12	Social Services	221,105		2,650	223,755		223,755		223,755			12
13	CNA Training											13
14	Program Transportation			1,830	1,830		1,830		1,830			14
15	Other (specify):* Mgmt Co Benefits Alloc							29,832	29,832			15
16	TOTAL Health Care and Programs	7,362,080	690,744	195,121	8,247,945		8,247,945	182,514	8,430,459			16
	C. General Administration											
17	Administrative	241,565		1,404,232	1,645,797		1,645,797	(1,178,451)	467,346			17
18	Directors Fees											18
19	Professional Services			488,330	488,330		488,330	10,739	499,069			19
20	Dues, Fees, Subscriptions & Promotions			80,425	80,425		80,425	(10,900)	69,525			20
21	Clerical & General Office Expenses	644,497	69,349	105,839	819,685		819,685	(33,939)	785,746			21
22	Employee Benefits & Payroll Taxes			1,550,236	1,550,236		1,550,236		1,550,236			22
23	Inservice Training & Education											23
24	Travel and Seminar			15,025	15,025		15,025	389	15,414			24
25	Other Admin. Staff Transportation			19,492	19,492		19,492	1,329	20,821			25
26	Insurance-Prop.Liab.Malpractice			291,846	291,846		291,846	5,234	297,080			26
27	Other (specify):* Mgmt Co Benefits Alloc							76,981	76,981			27
28	TOTAL General Administration	886,062	69,349	3,955,425	4,910,836		4,910,836	(1,128,618)	3,782,218			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	9,201,437	1,613,896	5,143,271	15,958,604		15,958,604	(936,119)	15,022,485			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: 1/1/2017 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							75,775	75,775			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			156,049	156,049		156,049	18,071	174,120			32
33	Real Estate Taxes			960,971	960,971		960,971		960,971			33
34	Rent-Facility & Grounds			4,454,426	4,454,426		4,454,426	27,653	4,482,079			34
35	Rent-Equipment & Vehicles			82,785	82,785		82,785	3,137	85,922			35
36	Other (specify):*											36
37	**TOTAL Ownership**			5,654,231	5,654,231		5,654,231	124,636	5,778,867			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		879,852	2,291,702	3,171,554		3,171,554	(344,044)	2,827,510			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			655,716	655,716		655,716		655,716			42
43	Other (specify):* **Disallowed Costs**		15,705	470,487	486,192		486,192	(486,192)				43
44	**TOTAL Special Cost Centers**		895,557	3,417,905	4,313,462		4,313,462	(830,236)	3,483,226			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	9,201,437	2,509,453	14,215,407	25,926,297		25,926,297	(1,641,719)	24,284,578			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: 1/1/2017 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	(5,600)	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	68,947	30		9
10	Interest and Other Investment Income	(8,166)	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	(115)	20		17
18	Fines and Penalties	(19,454)	43		18
19	Entertainment				19
20	Contributions	(23,400)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(24,580)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(383,313)	43		24
25	Fund Raising, Advertising and Promotional	(3,400)	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	(359,152)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (758,233)		$	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)	(883,486)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (883,486)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,641,719)		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: 1/1/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salary	(297,135)	21	1
2	Marketing Expense	(48,725)	43	2
3	PAC Dues	(12,527)	20	3
4	Theft & Damage Loss	(2,300)	43	4
5	Miscellaneous Income offset	(2,044)	21	5
6	Expense Repairs under $2,500	8,406	6	6
7	Disallow Marketing Travel Costs	(4,827)	25	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**	(359,152)		49

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/2017 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
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: 1/1/2017 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	5	Heat and Other Utilities	$	Premier Healthcare Management, LLC	100.00%	$ 1,397	$ 1,397	15
16	V	6	Maintenance		Premier Healthcare Management, LLC	100.00%	182	182	16
17	V	10	Nursing and Medical Records		Premier Healthcare Management, LLC	100.00%	178,439	178,439	17
18	V	10	Nursing and Medical Records		Premier Healthcare Management, LLC	100.00%	0		18
19	V	15	Emp Benefit Alloc-Healthcare		Premier Healthcare Management, LLC	100.00%	29,832	29,832	19
20	V	15	Emp Benefit Alloc-Healthcare		Premier Healthcare Management, LLC	100.00%	0		20
21	V	17	Administrative	1,404,232	Premier Healthcare Management, LLC	100.00%	181,350	(1,222,882)	21
22	V	17	Administrative		Premier Healthcare Management, LLC	100.00%	44,431	44,431	22
23	V	17	Administrative		Premier Healthcare Management, LLC	100.00%	0		23
24	V	19	Professional Services		Premier Healthcare Management, LLC	100.00%	10,667	10,667	24
25	V	20	Dues, Fees, Subs & Promo		Premier Healthcare Management, LLC	100.00%	1,046	1,046	25
26	V	21	Clerical & Gen Office Expenses		Premier Healthcare Management, LLC	100.00%	250,045	250,045	26
27	V	24	Travel and Seminar		Premier Healthcare Management, LLC	100.00%	389	389	27
28	V	25	Other Admin. Staff Trans		Premier Healthcare Management, LLC	100.00%	3,260	3,260	28
29	V	27	Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	69,553	69,553	29
30	V	27	Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	7,428	7,428	30
31	V	27	Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	0		31
32	V	34	Rent-Facility & Grounds		Premier Healthcare Management, LLC	100.00%	27,653	27,653	32
33	V	35	Equipment Rental		Premier Healthcare Management, LLC	100.00%	3,137	3,137	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,404,232			$ 808,809	$ * (595,423)	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: 1/1/2017 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	10	Nursing and Medical Records	$ 38,084	Premier Healthcare Supplies, LLC	100.00%	$ 15,540	$ (22,544)	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			$ 38,084			$ 15,540	$ * (22,544)	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: 1/1/2017 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. ☐ 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	$ 3,213	REX Therapeutics	100.00%	$	$ (3,213)	15
16	V	19	Professional Services		REX Therapeutics	100.00%	24,652	24,652	16
17	V	20	Fees and Subscriptions		REX Therapeutics	100.00%	696	696	17
18	V	21	Clerical & General Office Exp		REX Therapeutics	100.00%	15,195	15,195	18
19	V	25	Other Admin Staff Transp		REX Therapeutics	100.00%	2,896	2,896	19
20	V	26	Insurance-Prop.Liab.Malp		REX Therapeutics	100.00%	5,234	5,234	20
21	V	30	Depreciation		REX Therapeutics	100.00%	6,828	6,828	21
22	V	32	Interest Expense		REX Therapeutics	100.00%	26,237	26,237	22
23	V	39	Therapy Consultant		REX Therapeutics	100.00%	19,522	19,522	23
24	V	39	Therapy Management Wages		REX Therapeutics	100.00%	59,898	59,898	24
25	V	39	Allocated Employee Benefits		REX Therapeutics	100.00%	186,950	186,950	25
26	V								26
27	V	39	Therapy Wages		REX Therapeutics	100.00%	1,635,766	1,635,766	27
28	V	39	Contract Therapy	2,246,180	REX Therapeutics	100.00%		(2,246,180)	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			$ 2,249,393			$ 1,983,874	$ * (265,519)	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: 1/1/2017 Ending: 12/31/2017

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

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/2017 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	David Cheplowitz	Shareholder	Administrative	25.00%	See Att Sch 7A	8.63	22%	Alloc Salary	$ 37,990	17-7	1
2	Barak Baver	Shareholder	Administrative	25.00%	See Att Sch 7A	8.63	22%	Alloc Salary	37,990	17-7	2
3	Sara Baver	Relative	Clerical	0	See Att Sch 7A	8.63	22%	Alloc Salary	9,538	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	$ 85,518		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 Norridge Gardens # 0052431 Report Period Beginning: 1/1/2017 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: 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	428,856	12	$ 6,472	$	92,546	$ 1,397	1
2	6	Maintenance	Census Days	428,856	12	843		92,546	182	2
3	10	Nursing and Medical Records	Illinois Census Days	307,749	7	593,374	593,374	92,546	178,439	3
4	10	Nursing and Medical Records	Indiana Census Days	121,107	5	239,535	239,535		0	4
5	15	Emp Benefit Alloc-Healthcare	Illinois Census Days	307,749	7	99,203		92,546	29,832	5
6	15	Emp Benefit Alloc-Healthcare	Indiana Census Days	121,107	5	40,047			0	6
7	17	Administrative	Census Days	428,856	12	840,373	840,373	92,546	181,350	7
8	17	Administrative	Illinois Census Days	307,749	7	147,750	147,750	92,546	44,431	8
9	17	Administrative	Indiana Census Days	121,107	5	133,577	133,577		0	9
10	19	Professional Services	Census Days	428,856	12	49,430		92,546	10,667	10
11	20	Dues, Fees, Subs & Promo	Census Days	428,856	12	4,850		92,546	1,046	11
12	21	Clerical & Gen Office Expenses	Census Days	428,856	12	1,158,702	1,087,471	92,546	250,045	12
13	24	Travel and Seminar	Census Days	428,856	12	1,803		92,546	389	13
14	25	Other Admin. Staff Trans	Census Days	428,856	12	15,107		92,546	3,260	14
15	27	Emp Benefit Alloc-Gen Admin	Census Days	428,856	12	322,307		92,546	69,553	15
16	27	Emp Benefit Alloc-Gen Admin	Illinois Census Days	307,749	7	24,702		92,546	7,428	16
17	27	Emp Benefit Alloc-Gen Admin	Indiana Census Days	121,107	5	22,332			0	17
18	34	Rent-Facility & Grounds	Census Days	428,856	12	128,146		92,546	27,653	18
19	35	Equipment Rental	Census Days	428,856	12	14,538		92,546	3,137	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,843,091	$ 3,042,080		$ 808,809	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/2017 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: 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	161,406	12	$ 65,860	$	38,084	$ 15,540	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					$ 65,860	$		$ 15,540	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/2017 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: 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	5,071,121	7	$ 55,562	$	2,249,974	$ 24,652	1
2	20	Fees and Subscriptions	Therapy Revenue	5,071,121	7	1,569		2,249,974	696	2
3	21	Clerical & General Office Exp	Therapy Revenue	5,071,121	7	34,248		2,249,974	15,195	3
4	25	Other Admin Staff Transp	Therapy Revenue	5,071,121	7	6,528		2,249,974	2,896	4
5	26	Insurance-Prop.Liab.Malp	Therapy Revenue	5,071,121	7	11,796		2,249,974	5,234	5
6	30	Depreciation	Therapy Revenue	5,071,121	7	15,390		2,249,974	6,828	6
7	32	Interest Expense	Therapy Revenue	5,071,121	7	59,135		2,249,974	26,237	7
8	39	Therapy Consultant	Therapy Revenue	5,071,121	7	44,000		2,249,974	19,522	8
9	39	Therapy Management Wages	Therapy Revenue	5,071,121	7	135,002	135,002	2,249,974	59,898	9
10	39	Allocated Employee Benefits	Therapy Revenue	5,071,121	7	421,361		2,249,974	186,950	10
11										11
12	39	Therapy Wages	Direct Allocation	3,215,952	4	3,215,952	3,215,952	1,635,766	1,635,766	12
13	39	Contract Therapy	Direct Allocation	396,932	4	396,932				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					$ 4,397,475	$ 3,350,954		$ 1,983,874	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/2017 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												1
2												2
3												3
4												4
5												5
	Working Capital											
6	First Midwest Bank		X	Line of Credit		12/31/14		2,533,883	3/31/17		154,457	6
7												7
8												8
9	TOTAL Facility Related						$	$ 2,533,883			$ 154,457	9
	B. Non-Facility Related*											
10												10
11								Allocated from REX Therapeutics			26,237	11
12								Offset Interest Income			(8,166)	12
13								Other Interest Expense			1,592	13
14	TOTAL Non-Facility Related						$	$			$ 19,663	14
15	TOTALS (line 9+line14)						$	$ 2,533,883			$ 174,120	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:** 1/1/2017 **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.**	$	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.)	2016	$ 978,728	2
3. Under or (over) accrual (line 2 minus line 1).		$ 978,728	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 84,353	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** $ 219,948 **For** 13-15 **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ (102,110)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 960,971	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2012		8
2013	927,391	9
2014	942,879	10
2015	952,726	11
2016	978,728	12

Accrual based on prior year tax bill.

Note: Adjusted beginning accrual to actual balance.

	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 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 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.	13-18-318-005-0000	Long Term Care Propety	$ 261,369.32	$ 261,369.32
2.	13-18-318-006-0000	Long Term Care Propety	$ 231,918.58	$ 231,918.58
3.	13-18-318-007-0000	Long Term Care Propety	$ 233,887.66	$ 233,887.66
4.	13-18-318-008-0000	Long Term Care Propety	$ 251,552.29	$ 251,552.29
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 978,727.85	$ 978,727.85

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 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 Norridge Gardens # 0052431 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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: 1/1/2017 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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Replace Elevator Door Operator			2013	11,472		20	574	574	2,152	9
10	Replace Pumping Unit			2013	13,952		20	698	698	2,617	10
11	Boiler Repair & Rtu			2013	5,992		20	300	300	3,396	11
12	Build Wood Planters			2013	12,750		20	638	638	2,445	12
13	Sprinkler System Heads & Valves In Parking Lot Foyer & South Dock			2013	3,388		20	169	169	649	13
14	Install Awning & Sign			2013	8,944		20	447	447	1,603	14
15	Fire Sprinkler Repair			2014	2,929		20	146	146	512	15
16	Re-Doing Wiring And Computer Systems			2014	22,057		20	1,103	1,103	3,768	16
17	Repair Staircases On All 4 Floors			2014	6,600		20	330	330	1,045	17
18	Install Shunt Trip Breaker & Panelboard For Freight Elevator			2014	6,800		20	340	340	1,077	18
19	Hook Up Emergency Power & Fire Service Wiring			2014	5,010		20	251	251	773	19
20	Fire Doors			2014	3,000		20	150	150	450	20
21	Convert 2 Rms On 2Nd Floor To 2 Single Bedrms & Bathrm			2014	70,300		20	3,515	3,515	10,545	21
22	Fire Doors			2014	3,360		20	168	168	504	22
23	Water Heater Surface Ignitor			2014	3,957		20	198	198	2,111	23
24	Hot Water Pump Motor			2014	2,500		20	125	125	385	24
25	Install New Elevator Care Doors			2014	2,669		20	133	133	1,245	25
26	Install New Elevator Care Doors			2014	2,669		20	133	133	1,023	26
27	All Areas Carpet & Millwork Cove Base, Bathroom Tile			2014	31,551		20	1,578	1,578	4,733	27
28	Install New Elevator Care Doors			2014	2,669		20	133	133	389	28
29	Fire Alarm System			2014	4,270		20	214	214	552	29
30	Sprinkler System Repair			2014	2,523		20	126	126	336	30
31	Fire Alarm Repair			2014	3,264		20	163	163	517	31
32	Replace Packing & Repair Leaking Valves			2014	2,974		20	149	149	421	32
33	Hot Water Storage Tank Replacement With Wiring/Piping			2015	7,500		20	375	375	1,125	33
34	Idph Construction Application/Architects/Hvac/Electrical/Sprinkler			2015	8,496		20	425	425	1,275	34
35	Provide/Install New A/C Unit/Electrical Wiring For Lunch Room			2015	5,500		20	275	275	825	35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/2017 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	Kitchen Cabinets/Counter Tops For 2Nd/3Rd Floor Dining Rooms	2015	2,662		20	133	$ 133	$ 399	37
38	Install Cabinets/Countertops/Plumbing For 2Nd/3Rd Floor Dining	2015	$ 3,550	$	20	$ 178	178	534	38
39	Structural Engineering/Calculations/Analysis For Floor Addition I	2015	7,500		20	375	375	1,125	39
40	Provide/Install New Circuits Quad Outlets In 2Nd/3Rd Floor Spec	2015	2,680		20	134	134	402	40
41	Design Fees For First Floor Remodeling	2015	10,000		20	500	500	1,500	41
42	Replace Relief Device/Leak & Commission Test/Re-Insulate Tank	2015	7,500		20	375	375	1,125	42
43	Amstadter Construction Documents Detailed Architectural Design	2015	10,000		20	500	500	1,500	43
44	First Floor Remodel/Mechanical/Electrical/Plumbing/& Fire Prote	2015	10,000		20	500	500	1,500	44
45	Design Sketches First Floor Plans/Interior Elevations/Ceiling Plan	2015	10,000		20	500	500	1,500	45
46	Remove/Install New Retro Drains/Saddle For Roof/Iso Roofing Co	2015	3,200		20	160	160	480	46
47	Amstadter Architectural Design Fees	2015	10,000		20	500	500	1,500	47
48	Test/Replace Drive In Control System Contractor For Elevator	2015	2,932		20	147	147	441	48
49	Drilling 0-25'/Patching Of Asphalt/Soil Classification/ Project Rev	2015	4,360		20	218	218	654	49
50	Fertilization/Planting Flowers/Shrub & Tree Trimming In Back P	2015	2,730		20	137	137	411	50
51	Modify Pit Ladder/Hoistway Doors/Hatch Latch Door Restrictor I	2015	7,358		20	368	368	1,104	51
52	Replace/Repair leaking heat pipes & boiler water lines-2nd & 3rd	2016	4,238		20	212	212	318	52
53	Repaired Heat Exchanger	2016	3,528		20	176	176	264	53
54	Repair and Paint Walls in Office, Conference Rm & Kitchen	2016	5,425		20	271	271	407	54
55	Replace Tiles in Therapy Room	2016	3,900		20	195	195	293	55
56	Install Wanderguard Signalling Device	2016	3,454		20	173	173	259	56
57	New Refrigeration System with Indoor Remote Condensing	2016	11,399		20	570	570	855	57
58	2 9500 BTU Replacement units and 2 PTAC Units	2016	5,805		20	290	290	435	58
59	Carpet/Flooring - Lobby, Business Office, Conference Rm & Ente	2016	4,472		20	224	224	336	59
60	Replace Damaged Floor Tiles in Kitchen	2016	2,650		20	133	133	199	60
61	Install New Torsion-Spring Counter Balance Assembly	2016	2,650		20	133	133	199	61
62	Six new PTAC Units	2016	8,745		20	437	437	655	62
63	Install New 20 Ampere Circuitin Admissions Office	2017	5,000		20	125	125	125	63
64	Install 2 New 20 Ampere Circuits in Kitchen and 1 Power Pole	2017	3,500		20	88	88	88	64
65	Air Conditioner Repairs	2017	3,047		20	76	76	76	65
66	Replace Copper Piping and Strainer for Boiler	2017	3,032		20	76	76	76	66
67	Replace Bearing Assembly, Motor and Impeller for Boiler	2017	3,466		20	87	87	87	67
68	Six new PTAC Units	2017	8,553		20	214	214	214	68
69	Sprinkler System Repairs and Modifications - Maint. Office	2017	5,725		20	143	143	143	69
70	TOTAL (lines 4 thru 69)		$ 440,157	$		$ 21,204	$ 21,204	$ 65,677	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: 1/1/2017 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	
1	Totals from Page 12A, Carried Forward		$ 440,157	$		$ 21,204	$ 21,204	$ 65,677	1
2	Replace Sink and Cabinets in Utility Rm/Flooring in Ent Rm	2017	3,682		20	92	92	92	2
3	Luna Lights System	2017	4,000		20	100	100	100	3
4	Furnace Repairs	2017	4,680		20	117	117	117	4
5									5
6									6
7	Allocated from Premier Healthcare Management LLC.	2013	5,370		20	267	267	1,126	7
8									8
9									9
10									10
11	Allocated from REX Therapeutics					6,828	6,828		11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 457,889	$		$ 28,608	$ 28,608	$ 67,112	34

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: 1/1/2017 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	$ 466,446	$	$ 46,645	$ 46,645	10	$ 151,152	71
72	Current Year Purchases	10,440		522	522	10	522	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 476,886	$	$ 47,167	$ 47,167		$ 151,674	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)	$ 934,775	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)	$ 75,775	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 75,775	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 218,786	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	CIP	$ 9,780	92
93			93
94			94
95		$ 9,780	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 Norridge Gardens # 0052431 Report Period Beginning: 1/1/2017 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 ☐ 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	$ 4,454,426			3
4	Additions							4
5	Allocated from Management Co.				27,653			5
6								6
7	TOTAL		292		$ 4,482,079 **			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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 82,785 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	Allocated from Management Co			3,137	19
20					20
21	TOTAL		$	$ 3,137	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: **12/31/2017**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Nursing Equipment	49,726
Office Equipment	19,682
Storage Site	13,377
Total - Line 16	**82,785**

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/2017 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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/2017 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 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(7)	17051	hrs	$ 635,810		$	$	17,051	$ 635,810	1
2	Licensed Speech and Language Development Therapist	39(7)	5834	hrs	217,547				5,834	217,547	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A(2),39 (7)	22589	hrs	842,308			411	22,589	842,719	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				879,852		879,852	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify):										12
13	Other (specify): See Attached Scheule 16A				186,950		65,044			251,994	13
14	TOTAL				$ 1,882,615		$ 65,044	$ 880,263	45,474	$ 2,827,922	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: **12/31/2017**

Schedule 16A

XIV. Special Services
Line 13 Other Services

Description	Schedule V Line & Column Reference	Amount
Lab & Xray	39(3)	42,909
Outside MD Service-MCA	39(3)	2,613
Therapy Consultant	39(7)	19,522
Employee Benefits Allocated from REX	39(7)	186,950
Total - Line 13		**251,994**

STATE OF ILLINOIS

Facility Name & ID Number Norridge Gardens **#** 0052431 **Report Period Beginning:** 1/1/2017 **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	$ 38,123	$ 38,123	1
2	Cash-Patient Deposits	3,609	3,609	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 901,577)	5,162,227	5,162,227	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	126,095	126,095	6
7	Other Prepaid Expenses	103,596	103,596	7
8	Accounts Receivable (owners or related parties)	7,020,616	7,020,616	8
9	Other(specify): Due from Others	225,840	225,840	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 12,680,106	$ 12,680,106	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	502,654	457,889	15
16	Equipment, at Historical Cost	517,319	476,886	16
17	Accumulated Depreciation (book methods)	(322,227)	(218,786)	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	37,676,777	37,686,557	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 38,374,523	$ 38,402,546	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 51,054,629	$ 51,082,652	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,700,794	$ 3,700,794	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,261	2,261	28
29	Short-Term Notes Payable	2,533,883	2,533,883	29
30	Accrued Salaries Payable	687,022	687,022	30
31	Accrued Taxes Payable (excluding real estate taxes)	577,554	577,554	31
32	Accrued Real Estate Taxes(Sch.IX-B)	84,353	84,353	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	2,449,010	2,449,010	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 10,034,877	$ 10,034,877	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	37,940,293	37,940,293	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 37,940,293	$ 37,940,293	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 47,975,170	$ 47,975,170	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,079,459	$ 3,107,482	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 51,054,629	$ 51,082,652	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name: **Norridge Gardens**
IDPH License ID Number: **0052431**
Fiscal Year End: **12/31/2017**

Schedule 17A

XV. Balance Sheet

Line 23 Other Assets (specify):

Description	Operating	After Consolidation
CapEx Reserve	257,078	257,078
Building-Cap Lease	36,801,158	36,801,158
Unamortized Loan Costs	431,163	431,163
Principal Escrow	187,378	187,378
Construction in Progress		9,780
Total - Line 23	**37,676,777**	**37,686,557**

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Accrued MDS Tax	165,372	165,372
Accrued Expenses	639,663	639,663
Accrued Bed Tax	52,038	52,038
Payroll Withholdings	1,202,841	1,202,841
Security Deposits	290,032	290,032
Due to HFS	99,064	99,064
Total - Line 36	**2,449,010**	**2,449,010**

Facility Name & ID Number Norridge Gardens **#** 0052431 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,419,859	1
2	Restatements (describe):		2
3	**Post closing adjustments**	14,680	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,434,539	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(355,080)	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	( )	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)**	$ (355,080)	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)**	$ 3,079,459	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/2017 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	$ 24,966,201	1
2	Discounts and Allowances for all Levels	(217)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 24,965,984	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	542,564	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 542,564	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	162	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	35,581	19
20	Radiology and X-Ray		20
21	Other Medical Services	16,716	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 52,459	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,166	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,166	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	2,044	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,044	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 25,571,217	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,799,823	31
32	Health Care	8,247,945	32
33	General Administration	4,910,836	33
	B. Capital Expense		
34	Ownership	5,654,231	34
	C. Ancillary Expense		
35	Special Cost Centers	3,657,746	35
36	Provider Participation Fee	655,716	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 25,926,297	40
41	**Income before Income Taxes (line 30 minus line 40)****	(355,080)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (355,080)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 10,996,103	44
45	Private Pay - Net Inpatient Revenue	3,119,938	45
46	Medicare - Net Inpatient Revenue	9,865,094	46
47	Other-(specify) Insurance	984,849	47
48	Other-(specify) Hospice		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 24,965,984	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: 1/1/2017 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	1,888	2,200	$ 131,008	$ 59.55	1
2	Assistant Director of Nursing	5,817	6,419	253,866	39.55	2
3	Registered Nurses	56,943	62,836	1,961,121	31.21	3
4	Licensed Practical Nurses	41,198	43,292	1,202,978	27.79	4
5	CNAs & Orderlies	179,686	193,204	2,535,250	13.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	21,227	23,699	450,666	19.02	8
9	Activity Director					9
10	Activity Assistants	17,764	20,050	311,146	15.52	10
11	Social Service Workers	9,514	10,550	221,105	20.96	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	55,789	60,469	809,653	13.39	15
16	Dishwashers					16
17	Maintenance Workers	6,002	6,727	126,961	18.87	17
18	Housekeepers			16,681		18
19	Laundry					19
20	Administrator	4,416	5,253	241,565	45.99	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	23,172	25,459	644,497	25.32	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	3,858	4,415	83,563	18.93	31
32	Other Health Care(specify)					32
33	Other(specify) Care Plan Coordin	7,574	8,473	211,377	24.95	33
34	TOTAL (lines 1 - 33)	434,848	473,046	$ 9,201,437 *	$ 19.45	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	Monthly	$ 18,448	L1, C3	35
36	Medical Director	Monthly	54,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	47,995	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	Monthly	2,651	L11, C3	44
45	Social Service Consultant	Monthly	2,350	L12, C3	45
46	Other(specify) Rehab Mgmt	Monthly	24,000	L10a, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 149,444		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	Monthly	$ 12,955	L10, C3	50
51	Licensed Practical Nurses	287	13,760	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	287	$ 26,715		53

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Safet Keijalic	Administrator	0	$ 143,912
Shalom Lichtman	Administrator	0	28,503
Cecilia Ancona	Asst. Admin	0	47,017
Michael Jacobson	Asst. Admin	0	22,133
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 241,565

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 1,404,232
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,404,232
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 109,729
Richard Peelo & Associates, Inc	Accounting	2,100
CohnReznick LLP	Accounting	5,854
Ability Network Inc	Data Processing	4,368
ADP	Data Processing	6,052
SigmaCare	Data Processing	73,836
HDSI	Data Processing	3,059
Singer Networks, LLC	Data Processing	13,872
E-Solutions	Data Processing	4,766
LTC Consulting Services	Medical Billing Consulting	168,000
Terrill Consulting Services, Inc.	Billing Consultant	26,172
See Attached Schedule 21A		70,522
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 488,330

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 149,240
Unemployment Compensation Insurance	57,621
FICA Taxes	683,350
Employee Health Insurance	565,517
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	36,889
Physical Exams	2,700
Pension Contributions	54,919
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,550,236

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	19,566
Health Care Worker Background Check	
(Indicate # of checks performed 672)	22,053
Patient Background Checks 503	5,030
Dues & Subscriptions	2,405
Licenses & Permits	6,202
IL Council on LTC	12,527
Allocated from Management Co.	1,046
Allocated from REX Therapeutics	696
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 69,525

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	15,025
Allocated from Management Co.	389
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,414

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: **Norridge Gardens**
IDPH License ID Number: **0052431**
Fiscal Year End: **12/31/2017**

Schedule 21A

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
Medusind Solutions Inc.	Billing Consultant	11,651
Personnel Planners	UC Consultant	1,401
Zed System	Data Processing	351
M & M Financial	Financial Consultant	7,118
Change Healthcare	Data Processing	679
Paycor	Payroll Processing	47,585
IIT/Sourcetech	Computer Services	1,380
First American Title	Title Work	357
Total		**70,522**

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **12,527 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?

(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**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **101,236** 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. $ **655,716**
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