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: 0048470

Facility Name: Ridgeview Rehab & Nsg Center

Address: 6450 North Ridge Ave. (Number) Chicago (City) 60626 (Zip Code)

County: Cook

Telephone Number: (773) 743-8700 **Fax #** (773) 743-8407

HFS ID Number:

Date of Initial License for Current Owners: 9/1/2006

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: Steven N. Lavenda **Telephone Number:** (847) 282-6300
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 01/01/17 to 12/31/17 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)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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 Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	110	Skilled (SNF)	110	40,150	1
2		Skilled Pediatric (SNF/PED)			2
3	26	Intermediate (ICF)	26	9,490	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	136	TOTALS	136	49,640	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	15,250		4,838	20,088	8
9	SNF/PED					9
10	ICF	20,687	130	416	21,233	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,937	130	5,254	41,321	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.24%

D. How many bed reserve days during this year were paid by the Department?
None (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]

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 09/01/2006

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/01/2006 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 110 and days of care provided 3,138

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

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

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	244,082	46,452	8,172	298,706		298,706		298,706			1
2	Food Purchase		200,779		200,779		200,779	(6)	200,773			2
3	Housekeeping	189,717	42,347		232,064		232,064		232,064			3
4	Laundry	74,582	9,368		83,950		83,950		83,950			4
5	Heat and Other Utilities			141,565	141,565		141,565	(3,627)	137,938			5
6	Maintenance	73,899	18,821	77,884	170,604		170,604	(29,449)	141,155			6
7	Other (specify):*							543	543			7
8	TOTAL General Services	582,280	317,767	227,621	1,127,668		1,127,668	(32,539)	1,095,129			8
	B. Health Care and Programs											
9	Medical Director			12,600	12,600		12,600		12,600			9
10	Nursing and Medical Records	1,791,304	63,230	29,308	1,883,842		1,883,842	(15,334)	1,868,508			10
10a	Therapy	24,842		886	25,728		25,728		25,728			10a
11	Activities	100,822	1,539	1,104	103,465		103,465		103,465			11
12	Social Services	117,169		571	117,740		117,740		117,740			12
13	CNA Training											13
14	Program Transportation			623	623		623		623			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,034,137	64,769	45,092	2,143,998		2,143,998	(15,334)	2,128,664			16
	C. General Administration											
17	Administrative	109,603		541,200	650,803		650,803	(438,926)	211,877			17
18	Directors Fees											18
19	Professional Services			797,756	797,756	(146)	797,610	(684,164)	113,446			19
20	Dues, Fees, Subscriptions & Promotions			27,971	27,971		27,971	(10,064)	17,907			20
21	Clerical & General Office Expenses	114,888	36,253	403,754	554,895		554,895	(331,210)	223,685			21
22	Employee Benefits & Payroll Taxes			412,830	412,830		412,830		412,830			22
23	Inservice Training & Education											23
24	Travel and Seminar			970	970		970	161	1,131			24
25	Other Admin. Staff Transportation			3,095	3,095		3,095	4,983	8,078			25
26	Insurance-Prop.Liab.Malpractice			225,423	225,423		225,423	2,776	228,199			26
27	Other (specify):*							56,280	56,280			27
28	TOTAL General Administration	224,491	36,253	2,412,999	2,673,743	(146)	2,673,597	(1,400,164)	1,273,433			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,840,908	418,789	2,685,712	5,945,409	(146)	5,945,263	(1,448,037)	4,497,226			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 Ridgeview Rehab & Nsg Center #0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			23,167	23,167		23,167	206,764	229,931			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,273	6,273		6,273	179,461	185,734			32
33	Real Estate Taxes			186,000	186,000	146	186,146	58,821	244,966			33
34	Rent-Facility & Grounds			1,014,000	1,014,000		1,014,000	(1,014,000)				34
35	Rent-Equipment & Vehicles							5,601	5,601			35
36	Other (specify):*			33,333	33,333		33,333	(750)	32,583			36
37	TOTAL Ownership			1,262,773	1,262,773	146	1,262,919	(564,102)	698,816			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		65,589	423,888	489,477		489,477		489,477			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			306,279	306,279		306,279		306,279			42
43	Other (specify):*			1,120	1,120		1,120	(1,120)				43
44	TOTAL Special Cost Centers		65,589	731,287	796,876		796,876	(1,120)	795,756			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,840,908	484,378	4,679,772	8,005,058		8,005,058	(2,013,259)	5,991,799			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 Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	(5,066)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	64,171	30		9
10	Interest and Other Investment Income	(6,465)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(380,880)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(859,974)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,188,220)		$	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)	(825,039)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (825,039)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,013,259)		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

Ridgeview Rehab & Nsg Center

ID# 0048470

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Capitalized R&M	$ (38,945)	06	1
2	Pharmacy - V.A.	(12,837)	10	2
3	VA- Lab/X- Ray	(2,497)	10	3
4	Marketing Expense	(1,120)	43	4
5	MCA Sequester Reduction	(33,475)	21	5
6	Amortization	(33,333)	36	6
7	Bldg Co - Amortization	(1,789)	36	7
8	Bldg Co - Accountng Fees	(1,875)	19	8
9	Bldg Co - Audit Fees	(4,200)	19	9
10	Bldg Co - Illinois RT	(30,240)	21	10
11	Non Allowable Legal	(689,599)	19	11
12	PAC Dues	(10,064)	20	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**	(859,974)		49

Ridgeview Rehab & Nsg Center

ID# 0048470

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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													1
2	Food Purchase	(6)											(6)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(5,066)		1,439									(3,627)	5
6	Maintenance	(38,945)		4,243	5,253								(29,449)	6
7	Other (specify):*				543								543	7
8	**TOTAL General Services**	(44,017)		5,682	5,796								(32,539)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(15,334)											(15,334)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(15,334)											(15,334)	16
	C. General Administration													
17	Administrative			(510,185)	71,259								(438,926)	17
18	Directors Fees													18
19	Professional Services	(695,674)	6,075	4,633		802							(684,164)	19
20	Fees, Subscriptions & Promotions	(10,064)											(10,064)	20
21	Clerical & General Office Expenses	(444,595)	30,240	83,145									(331,210)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			161									161	24
25	Other Admin. Staff Transportation			4,983									4,983	25
26	Insurance-Prop.Liab.Malpractice			2,269		507							2,776	26
27	Other (specify):*			51,766	4,514								56,280	27
28	**TOTAL General Administration**	(1,150,333)	36,315	(363,228)	75,773	1,309							(1,400,164)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,209,684)	36,315	(357,546)	81,569	1,309							(1,448,037)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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	64,171	139,844	321		2,428							206,764	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(6,465)	184,335	7		1,584							179,461	32
33	Real Estate Taxes		51,637			7,184							58,821	33
34	Rent-Facility & Grounds		(1,014,000)	14,625		(14,625)							(1,014,000)	34
35	Rent-Equipment & Vehicles			5,601									5,601	35
36	Other (specify):*	(35,122)	34,372										(750)	36
37	TOTAL Ownership	22,584	(603,811)	20,554		(3,429)							(564,102)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(1,120)											(1,120)	43
44	TOTAL Special Cost Centers	(1,120)											(1,120)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,188,220)	(567,496)	(336,992)	81,569	(2,120)							(2,013,259)	45

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Income	$ 1,014,000	Ridgeview Rehab Realty, LLC	100.00%	$	$ (1,014,000)	1
2	V	32	Interest Income	129	Ridgeview Rehab Realty, LLC	100.00%		(129)	2
3	V	36	MIP Insurance		Ridgeview Rehab Realty, LLC	100.00%	32,584	32,584	3
4	V	33	Real Estate Taxes	186,000	Ridgeview Rehab Realty, LLC	100.00%	237,637	51,637	4
5	V		Prior Year RE Tax Refund	12,372	Ridgeview Rehab Realty, LLC	100.00%		(12,372)	5
6	V	32	Mortgage Interest - Greystone		Ridgeview Rehab Realty, LLC	100.00%	184,464	184,464	6
7	V	30	Depreciation		Ridgeview Rehab Realty, LLC	100.00%	139,844	139,844	7
8	V	36	Amortization of Loan Fees - Greystone		Ridgeview Rehab Realty, LLC	100.00%	1,789	1,789	8
9	V	19	Accounting Fees		Ridgeview Rehab Realty, LLC	100.00%	1,875	1,875	9
10	V	19	Audit Fees		Ridgeview Rehab Realty, LLC	100.00%	4,200	4,200	10
11	V	21	Illinois RT		Ridgeview Rehab Realty, LLC	100.00%	30,240	30,240	11
12	V								12
13	V								13
14	Total			$ 1,212,501			$ 632,633	$ * (579,868)	14

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

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	STAYCARE MANAGEMENT, LTD.	100.00%	$ 1,439	$ 1,439	15
16	V	6	REPAIRS AND MAINT.		STAYCARE MANAGEMENT, LTD.	100.00%	4,243	4,243	16
17	V	17	ADMIN. SALARY		STAYCARE MANAGEMENT, LTD.	100.00%	31,015	31,015	17
18	V	19	PROFESSIONAL FEES		STAYCARE MANAGEMENT, LTD.	100.00%	4,633	4,633	18
19	V	21	CLERICAL & GENERAL - SALARIES		STAYCARE MANAGEMENT, LTD.	100.00%	71,977	71,977	19
20	V	21	CLERICAL & GENERAL - OTHER		STAYCARE MANAGEMENT, LTD.	100.00%	11,168	11,168	20
21	V	24	SEMINARS		STAYCARE MANAGEMENT, LTD.	100.00%	161	161	21
22	V	25	ADMIN. STAFF TRAVEL		STAYCARE MANAGEMENT, LTD.	100.00%	4,983	4,983	22
23	V	26	INSURANCE		STAYCARE MANAGEMENT, LTD.	100.00%	2,269	2,269	23
24	V	27	EMPLOYEE BENEFITS		STAYCARE MANAGEMENT, LTD.	100.00%	51,766	51,766	24
25	V	30	DEPRECIATION		STAYCARE MANAGEMENT, LTD.	100.00%	321	321	25
26	V	32	INTEREST		STAYCARE MANAGEMENT, LTD.	100.00%	7	7	26
27	V	34	BUILDING RENT		STAYCARE MANAGEMENT, LTD.	100.00%	14,625	14,625	27
28	V	35	EQUIP. RENTAL-AUTO		STAYCARE MANAGEMENT, LTD.	100.00%	5,601	5,601	28
29	V								29
30	V	17	MANAGEMENT FEES	541,200	STAYCARE MANAGEMENT, LTD.	100.00%		(541,200)	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			$ 541,200			$ 204,208	$ * (336,992)	39

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

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1	DIET. COMP - S. WEBSTER	$	STAY CARE MANAGEMENT, LTD.	100.00%	$	$	15
16	V	1	DIET. COMP - D. WENGROW		STAY CARE MANAGEMENT, LTD.	100.00%			16
17	V	6	MAINT. COMP.		STAY CARE MANAGEMENT, LTD.	100.00%	5,253	5,253	17
18	V	7	EMP. BEN. - S. WEBSTER		STAY CARE MANAGEMENT, LTD.	100.00%			18
19	V	7	EMP. BEN. - D. WENGROW		STAY CARE MANAGEMENT, LTD.	100.00%			19
20	V	7	EMP. BEN. - MAINT. NON-OWNER		STAY CARE MANAGEMENT, LTD.	100.00%	543	543	20
21	V	17	ADMIN. COMP - H. WENGROW		STAY CARE MANAGEMENT, LTD.	100.00%	14,245	14,245	21
22	V	17	ADMIN. COMP - J. WEBSTER		STAY CARE MANAGEMENT, LTD.	100.00%	57,014	57,014	22
23	V	27	EMP. BEN. - H. WENGROW		STAY CARE MANAGEMENT, LTD.	100.00%	942	942	23
24	V	27	EMP. BEN. - J. WEBSTER		STAY CARE MANAGEMENT, LTD.	100.00%	3,572	3,572	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			$			$ 81,569	$ * 81,569	39

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

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	19	PROFESSIONAL FEES		DOUBLE YOU REALTY, LLC	100.00%	656	$ 656	15
16	V	26	INSURANCE		DOUBLE YOU REALTY, LLC	100.00%	507	507	16
17	V	30	DEPRECIATION		DOUBLE YOU REALTY, LLC	100.00%	2,428	2,428	17
18	V	32	INTEREST EXPENSE		DOUBLE YOU REALTY, LLC	100.00%	1,584	1,584	18
19	V	19	RE TAX PROFESSIONAL FEES		DOUBLE YOU REALTY, LLC	100.00%	146	146	19
20	V	33	REAL ESTATE TAXES		DOUBLE YOU REALTY, LLC	100.00%	7,184	7,184	20
21	V								21
22	V	34	RENT	14,625	DOUBLE YOU REALTY, LLC	100.00%		(14,625)	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			$ 14,625			$ 12,505	$ * (2,120)	39

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

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	ABRAHAM J. STERN	2.94%	ABBINGTON REHAB	ROSELLE	RIDGEVIEW REALTY, LLC	LINCOLNWOOD	BUILDING CO.	1
2	HOWARD BERNATH	2.21%	ARBOUR HEALTH CARE CENTER, LTD.	CHICAGO	DOUBLE YOU REALTY	LINCOLNWOOD	BUILDING COMPANY	2
3	HOWARD L WENGROW	29.41%	ATRIUM HEALTH CARE CENTER, LTD., THE	CHICAGO	STAYCARE MANAGEMENT	LINCOLNWOOD	MANAGEMENT, BOOKKEEI	3
4	JEFFREY J WEBSTER	29.41%	HICKORY NURSING PAVILION, INC.	HICKORY HILLS				4
5	MARCIA MORGAN	3.68%	ZIKAINIM, INC. D/B/A ALL AMERICAN NURSING HOME	CHICAGO				5
6	RICHARD SGARLATA	0.16%						6
7	SHIMON WEBSTER	14.71%						7
8	YERUCHOM LEVOVITZ	14.71%						8
9	BETSY ANDERSON	0.16%						9
10	GARY BARRON	0.16%						10
11	CARY BUXBAUM	0.16%						11
12	GARY CHANKIN	0.08%						12
13	ROBERT COHEN	0.16%						13
14	ANDREW CUTLER	0.16%						14
15	NOSHIR DARUWALLA	0.16%						15
16	ELIEZER HILDESHAIM	0.16%						16
17	STEVEN LAVENDA	0.16%						17
18	GARY ROSE	0.16%						18
19	ARTHUR ROTHBLATT	0.16%						19
20	STEVEN SILBERMAN	0.16%						20
21	JEFFREY SINGER	0.16%						21
22	FREDERICK COOPERMAN LIVING TRUST	0.16%						22
23	ROBERT ROSE	0.16%						23
24	HARVEY MARGOLIS TRUST	0.16%						24
25	EDWARD SLACK	0.16%						25
26	JANET CHANKIN	0.08%						26
27								27
28								28
29								29
30								30

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

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

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Jeffrey Webster	Owner	Administrative	29.41%	See Attached	20	28.57%	Alloc. Salary	$ 57,014	17-07	1
2	Howard Wengrow	Owner	Administrative	29.41%	See Attached	5	7.69%	Alloc. Salary	14,245	17-07	2
3	Ephraim Braunstein	Relative	Clerical		See Attached	7.93	19.83%	Alloc. Salary	16,961	21-07	3
4	Howard Bernath	Owner	Maintenance	2.21%	See Attached	7.93	19.83%	Alloc. Salary	5,253	06-07	4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 93,473		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 Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: STAYCARE MANAGEMENT, LTD.
Street Address: 3737 W ARTHUR AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: ((847) 679-2121
Fax Number: ((847) 679-2122

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	208,514	6	$ 7,261	$	41,321	$ 1,439	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	208,514	6	21,410		41,321	4,243	2
3	17	ADMIN. SALARY	PATIENT DAYS	208,514	6	156,508	156,508	41,321	31,015	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	208,514	6	23,378		41,321	4,633	4
5	21	CLERICAL & GENERAL - SALA	PATIENT DAYS	208,514	6	363,209	363,209	41,321	71,977	5
6	21	CLERICAL & GENERAL - OTH	PATIENT DAYS	208,514	6	56,356		41,321	11,168	6
7	24	SEMINARS	PATIENT DAYS	208,514	6	810		41,321	161	7
8	25	ADMIN. STAFF TRAVEL	PATIENT DAYS	208,514	6	25,144		41,321	4,983	8
9	26	INSURANCE	PATIENT DAYS	208,514	6	11,450		41,321	2,269	9
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	208,514	6	261,220		41,321	51,766	10
11	30	DEPRECIATION	PATIENT DAYS	208,514	6	1,621		41,321	321	11
12	32	INTEREST	PATIENT DAYS	208,514	6	34		41,321	7	12
13	34	BUILDING RENT	PATIENT DAYS	208,514	6	73,800		41,321	14,625	13
14	35	EQUIP. RENTAL-AUTO	PATIENT DAYS	208,514	6	28,262		41,321	5,601	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,030,464	$ 519,717		$ 204,208	25

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: STAYCARE MANAGEMENT, LTD.
Street Address: 3737 W ARTHUR AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: ((847) 679-2121
Fax Number: ((847) 679-2122

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIET. COMP - S. WEBSTER	AVG. HOURS WORKED	5	4	10,104	10,104			1
2	1	DIET. COMP - D. WENGROW	AVG. HOURS WORKED	5	4	30,000	30,000			2
3	6	MAINT. COMP.	AVG. HOURS WORKED	40	6	26,510	26,510	8	5,253	3
4	7	EMP. BEN. - S. WEBSTER	AVG. HOURS WORKED	5	4	928				4
5	7	EMP. BEN. - D. WENGROW	AVG. HOURS WORKED	5	4	2,524				5
6	7	EMP. BEN. - MAINT. NON-OWN	AVG. HOURS WORKED	40	6	2,741		8	543	6
7	17	ADMIN. COMP - H. WENGROW	AVG. HOURS WORKED	65	6	185,182	185,182	5	14,245	7
8	17	ADMIN. COMP - J. WEBSTER	AVG. HOURS WORKED	70	6	199,550	199,550	20	57,014	8
9	27	EMP. BEN. - H. WENGROW	AVG. HOURS WORKED	65	6	12,252		5	942	9
10	27	EMP. BEN. - J. WEBSTER	AVG. HOURS WORKED	70	6	12,502		20	3,572	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					$ 482,293	$ 451,346		$ 81,569	25

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: DOUBLE YOU REALTY, LLC
Street Address: 3737 W. ARTHUR AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: ((847) 679-2121
Fax Number: ((847) 679-2122

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	208,514	6	3,310		41,321	656	1
2	26	INSURANCE	PATIENT DAYS	208,514	6	2,559		41,321	507	2
3	30	DEPRECIATION	PATIENT DAYS	208,514	6	12,254		41,321	2,428	3
4	32	INTEREST EXPENSE	PATIENT DAYS	208,514	6	7,994		41,321	1,584	4
5	19	RE TAX PROFESSIONAL FEES	PATIENT DAYS	208,514	6	735		41,321	146	5
6	33	REAL ESTATE TAXES	PATIENT DAYS	208,514	6	36,251		41,321	7,184	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					$ 63,103	$		$ 12,505	25

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Greystone		X	Mortgage			$	$ 5,866,352			$ 184,464	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB Financial		X								6,273	6
7												7
8												8
9	TOTAL Facility Related						$	$ 5,866,352			$ 190,737	9
	B. Non-Facility Related*											
10	Interest Income		X								(6,465)	10
11	Interest Income - Bldg Co		X								(129)	11
12	Allocated from Staycare	X									7	12
13	See Supplemental Schedule										1,584	13
14	TOTAL Non-Facility Related						$	$			$ (5,003)	14
15	TOTALS (line 9+line14)						$	$ 5,866,352			$ 185,734	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 32,584 Line # 36

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

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

Facility Name & ID Number Ridgeview Rehab & Nsg Center **#** 0048470 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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.**	$ 205,000	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.)		$ 224,821	2
3. Under or (over) accrual (line 2 minus line 1).		$ 19,821	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 225,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$ 146	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** $ 438 **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.		$ 244,967	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	172,029	8
	2013	174,357	9
	2014	177,870	10
	2015	199,118	11
	2016	217,637	12

2017 Accrual = $217,637 x 1.03 = $225,000 (Rounded)

Allocated from Double You Realty = $7,184

	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 Ridgeview Rehab & Nsg Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048470

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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.	11-31-401-068-0000	Long Term Care Property	$ 44,072.50	$ 44,072.50
2.	11-31-401-088-0000	Long Term Care Property	$ 173,564.34	$ 173,564.34
3.	10-35-329-014-0000	Home Office Property	$ 23,388.05	$ 4,634.79
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 241,024.89	$ 222,271.63

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Ridgeview Rehab & Nsg Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0048470

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 29,742 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

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

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

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

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

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

None

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

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

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2006	$ 299,380	1
2	Allocated from Double You Realty			9,908	2
3	TOTALS			$ 309,288	3

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	136		2006	1975	$ 4,498,315	$ 139,844	30	$ 149,944	$ 10,100	$ 1,534,961	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2007	49,309		20	2,809	2,809	38,433	9
10	Various			2008	86,546		20	4,759	4,759	45,250	10
11	Various			2009	149,154		20	5,713	5,713	83,608	11
12	Various			2010	108,070		20	5,405	5,405	41,058	12
13	Various			2011	79,411		20	3,970	3,970	26,475	13
14	Various			2012	25,222		20	2,710	2,710	15,708	14
15	Various			2013	69,570		20	8,166	8,166	37,807	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

*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 Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		104,250	2,428		2,905	477	39,951	68
69	Financial Statement Depreciation			23,167			(23,167)		69
70	TOTAL (lines 4 thru 69)		$ 5,169,847	$ 165,439		$ 186,381	$ 20,942	$ 1,863,251	70

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

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 5,169,847	$ 165,439		$ 186,381	$ 20,942	$ 1,863,251	1
2	New P-Trap, Rodd Sewer Line, Repair Concrete In Kitchen	2014	3,500		20	175	175	642	2
3	Remove & Replace 2 Boiler Tubes	2014	4,150		20	208	208	744	3
4	Install 5 Ton Comfortmaker, Airhandler, Cooperlines & Thermos	2014	9,000		20	450	450	1,613	4
5	Install Fire Annuciator	2014	2,725		20	136	136	488	5
6	Install Cove Base, Wall Covering, & Prep Walls In Dayroom	2014	6,782		20	339	339	1,046	6
7	Remove & Install 6 Inch Main Valve Pump In Corridor Alcove	2014	11,980		20	599	599	1,947	7
8	Water Heater	2015	9,052		20	453	453	1,131	8
9	Elevator Floor Repairs & Cove Base Install	2016	3,119		20	624	624	988	9
10	Custom Built-In Nursing Station Cabinetry	2016	11,090		20	2,218	2,218	3,327	10
11	Tee Jay Service - Door Locks & Sensors	2017	3,424		20	57	57	57	11
12	New Call System	2017	9,790		20	326	326	326	12
13	Miracle Plumbing 2Nd Fl & Basement Piping & Fittings	2017	4,600		20	211	211	211	13
14	South Boiler Circulation Pump	2017	2,586		20	97	97	97	14
15	Cover Lights On Third Floor	2017	3,080		20	154	154	154	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)		$ 5,254,725	$ 165,439		$ 192,428	$ 26,989	$ 1,876,022	34

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

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,254,725	$ 165,439		$ 192,428	$ 26,989	$ 1,876,022	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
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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)		$ 5,254,725	$ 165,439		$ 192,428	$ 26,989	$ 1,876,022	34

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

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 5,254,725	$ 165,439		$ 192,428	$ 26,989	$ 1,876,022	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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)		$ 5,254,725	$ 165,439		$ 192,428	$ 26,989	$ 1,876,022	34

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

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 5,254,725	$ 165,439		$ 192,428	$ 26,989	$ 1,876,022	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,254,725	$ 165,439		$ 192,428	$ 26,989	$ 1,876,022	34

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

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Double You Realty	2003	94,711	2,428	35	2,428		36,329	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Staycare Management	2003	4,387		20	219	219	3,193	9
10	Allocated from Staycare Management	2016	5,152		20	258	258	429	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 104,250	$ 2,428		$ 2,905	$ 477	$ 39,951	34

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

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 104,250	$ 2,428		$ 2,905	$ 477	$ 39,951	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
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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)		$ 104,250	$ 2,428		$ 2,905	$ 477	$ 39,951	34

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

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 258,048	$	$ 34,797	$ 34,797	10	$ 185,333	71
72	Current Year Purchases	25,255		1,889	1,889	10	1,889	72
73	Fully Depreciated Assets	1,249,788				10	1,249,788	73
74								74
75	TOTALS	$ 1,533,091	$	$ 36,686	$ 36,686		$ 1,437,010	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Staycare Manage	2017	$ 6,707	$ 321	$ 817	$ 496	5	$ 5,175	76
77										77
78										78
79										79
80	TOTALS			$ 6,707	$ 321	$ 817	$ 496		$ 5,175	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)	$ 7,103,811	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 165,760	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 229,931	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 64,171	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,318,207	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 Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/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: $ Description:
(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	Allocated from Staycare		$	$ 5,601	17
18					18
19					19
20					20
21	TOTAL		$	$ 5,601	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 Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 157,944	$		$ 157,944	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			36,407			36,407	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			229,537			229,537	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				65,589		65,589	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			$		$ 423,888	$ 65,589		$ 489,477	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 Ridgeview Rehab & Nsg Center **#** 0048470 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/17 **(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	$ 883,291	$ 2,861,656	1
2	Cash-Patient Deposits	111,620	111,620	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,268,943	1,268,943	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	310,460	310,460	6
7	Other Prepaid Expenses	1,822	1,822	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule		524,559	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,576,136	$ 5,079,060	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		600,000	13
14	Buildings, at Historical Cost		3,760,866	14
15	Leasehold Improvements, at Historical Cost	659,488	705,774	15
16	Equipment, at Historical Cost	181,824	1,420,367	16
17	Accumulated Depreciation (book methods)	(583,155)	(3,400,390)	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	126,031	170,296	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 384,188	$ 3,256,913	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,960,324	$ 8,335,973	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 589,392	$ 589,390	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	111,620	111,620	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	195,240	195,240	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,138	3,138	31
32	Accrued Real Estate Taxes(Sch.IX-B)		225,000	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	82,492	82,492	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 981,882	$ 1,206,880	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,866,352	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	578,266		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 578,266	$ 5,866,352	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,560,148	$ 7,073,232	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,400,176	$ 1,262,741	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,960,324	$ 8,335,973	48

***(See instructions.)**

Facility Name & ID Number Ridgeview Rehab & Nsg Center **#** 0048470 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,178,217	1
2	Restatements (describe):		2
3	Rounding	3	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,178,220	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	221,956	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)**	$ 221,956	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,400,176	24 *

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

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 8,004,124	1
2	Discounts and Allowances for all Levels	(765,650)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,238,474	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	905,002	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 905,002	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	67,495	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,925	19
20	Radiology and X-Ray		20
21	Other Medical Services	5,653	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 77,073	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,465	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,465	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,227,014	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,127,668	31
32	Health Care	2,143,998	32
33	General Administration	2,673,743	33
	B. Capital Expense		
34	Ownership	1,262,773	34
	C. Ancillary Expense		
35	Special Cost Centers	490,597	35
36	Provider Participation Fee	306,279	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,005,058	40
41	**Income before Income Taxes (line 30 minus line 40)****	221,956	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 221,956	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,463,643	44
45	Private Pay - Net Inpatient Revenue	133,589	45
46	Medicare - Net Inpatient Revenue	1,231,519	46
47	Other-(specify) Veterans	409,723	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,238,474	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis 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 Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	4,120	4,329	$ 168,200	$ 38.85	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,106	6,638	193,861	29.20	3
4	Licensed Practical Nurses	25,210	26,813	721,910	26.92	4
5	CNAs & Orderlies	42,079	46,250	554,848	12.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,788	2,027	24,842	12.26	8
9	Activity Director	1,824	2,024	28,384	14.02	9
10	Activity Assistants	5,842	6,259	72,438	11.57	10
11	Social Service Workers	5,918	6,274	117,169	18.68	11
12	Dietician					12
13	Food Service Supervisor	1,864	2,080	31,539	15.16	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,400	18,601	212,543	11.43	15
16	Dishwashers					16
17	Maintenance Workers	4,040	4,352	73,899	16.98	17
18	Housekeepers	14,660	16,083	189,717	11.80	18
19	Laundry	5,145	5,679	74,582	13.13	19
20	Administrator	1,976	2,152	109,603	50.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,918	8,290	114,888	13.86	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	723	747	11,459	15.34	31
32	Other Health Care(specify)					32
33	Other(specify)	3,864	4,192	141,026	33.64	33
34	TOTAL (lines 1 - 33)	150,477	162,790	$ 2,840,908 *	$ 17.45	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	Monthly	$ 8,172	01-03	35
36	Medical Director	Monthly	12,600	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	11,308	10-03	39
40	Physical Therapy Consultant	13	672	10a-03	40
41	Occupational Therapy Consultant	3	135	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly	79	10a-03	43
44	Activity Consultant	Monthly	1,104	11-03	44
45	Social Service Consultant	10	571	12-03	45
46	Other(specify) MDS Consulting	Monthly	18,000	10-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	26	$ 52,641		49

C. CONTRACT NURSES

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

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Debra Brown	Administrator	0	$ 109,603
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 109,603

B. Administrative - Other

Description	Amount
Staycare - Management Fees	$ 541,200
TOTAL (agree to Schedule V, line 17, col. 3)	$ 541,200
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 23,372
Personnel Planners	Unemployment Consultant	943
See Attached	Legal Fees	716,963
Staycare Management	Admissions Consulting	24,362
eHealth Solutions, Inc.	E-Charting	27,798
KBC Computer Services	Computer Services	4,318
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 797,756

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 57,495
Unemployment Compensation Insurance	26,020
FICA Taxes	211,731
Employee Health Insurance	91,288
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension Expense	18,443
401K - Employer	355
Christmas Expense	6,935
Employee Benefits	562
TOTAL (agree to Schedule V, line 22, col.8)	$ 412,829

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 928
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 290)	2,900
Patient Background Checks	
Dues & Subscriptions	10,064
Licenses & Permits	4,015
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,907

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	970
Allocated from Staycare	161
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,131

**See instructions.

Facility Name & ID Number Ridgeview Rehab & Nsg Center # 0048470 Report Period Beginning: 01/01/17 Ending: 12/31/17

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC = $20,128**

(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? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **8,677** 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 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. $ **306,279**
This amount is to be recorded on line 42 of Schedule V.

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

(13) Have costs for all supplies and services which are of the type that can be billed 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. $ Has any meal income been offset against
related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation 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? **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? **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