FOR BHF USE

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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: 0039255

Facility Name: PARK RIDGE CARE CENTER

Address: 665 BUSSE HIGHWAY (Number) PARK RIDGE (City) 60068 (Zip Code)

County: COOK

Telephone Number: (847) 679-8219 **Fax #** (847) 679-7377

HFS ID Number:

Date of Initial License for Current Owners: 12/1/1993

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: KATHLEEN MCNAMARA **Telephone Number:** (847) 675-3585
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 01/01/2018 to 12/31/2018 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) MARSHALL MAUER
(Title) ASSISTANT SECRETARY

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) KATHLEEN MCNAMARA, VICE-PRESIDENT
(Firm Name & Address) KBKB, LTD, 8140 RIVER DRIVE, MORTON GROVE, IL 60053
(Telephone) (847) 675-3585 Fax # (847) 675-5777

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 PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	46	Skilled (SNF)	46	16,790	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	46	TOTALS	46	16,790	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			1,102	1,102	8
9	SNF/PED					9
10	ICF	13,480	81		13,561	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,480	81	1,102	14,663	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.33%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

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

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

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 12/1/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/1/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 46 and days of care provided 1,062

Medicare Intermediary WISCONSIN PHYSICIANS SERVICE

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	177,127	12,243	50	189,420		189,420	(81)	189,339			1
2	Food Purchase		66,905		66,905	(3,176)	63,729		63,729			2
3	Housekeeping	80,092	19,206		99,298		99,298		99,298			3
4	Laundry	30,170	10,397	1,531	42,098		42,098		42,098			4
5	Heat and Other Utilities			34,184	34,184		34,184	511	34,695			5
6	Maintenance	47,478	16,927	18,997	83,402		83,402	2,859	86,261			6
7	Other (specify):*			7,832	7,832		7,832	348	8,180			7
8	**TOTAL General Services**	334,867	125,678	62,594	523,139	(3,176)	519,963	3,637	523,600			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	969,129	48,909	7,939	1,025,977		1,025,977		1,025,977			10
10a	Therapy											10a
11	Activities	68,169	8,329	652	77,150		77,150		77,150			11
12	Social Services			780	780		780		780			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,037,298	57,238	15,371	1,109,907		1,109,907		1,109,907			16
	C. General Administration											
17	Administrative	132,852			132,852		132,852	29,136	161,988			17
18	Directors Fees											18
19	Professional Services			45,057	45,057		45,057	1,585	46,642			19
20	Dues, Fees, Subscriptions & Promotions			20,310	20,310		20,310	(5,319)	14,991			20
21	Clerical & General Office Expenses	20,963	8,133	50,328	79,424		79,424	2,826	82,250			21
22	Employee Benefits & Payroll Taxes			177,841	177,841	3,176	181,017		181,017			22
23	Inservice Training & Education			448	448		448		448			23
24	Travel and Seminar			4,193	4,193		4,193	238	4,431			24
25	Other Admin. Staff Transportation							2,488	2,488			25
26	Insurance-Prop.Liab.Malpractice			92,525	92,525		92,525	4,432	96,957			26
27	Other (specify):*			158,841	158,841		158,841	(130,942)	27,899			27
28	**TOTAL General Administration**	153,815	8,133	549,543	711,491	3,176	714,667	(95,556)	619,111			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,525,980	191,049	627,508	2,344,537		2,344,537	(91,919)	2,252,618			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#: PARK RIDGE CARE CENTER **#0039255** **Report Period Beginning: 01/01/2018** **Ending: 12/31/2018**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	50	
	REPAIRS & MAINTENANCE			
				50
3	**HOUSEKEEPING**			
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,531	
				1,531
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		5,140	
	ELECTRICITY		18,736	
	WATER		10,308	
	CABLE TV - LOBBY			
				34,184
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		11,325	
	PAINTING & DECORATING		228	
	BUILDING REPAIRS			
	MAINTENANCE TRAVEL			
	EQUIPMENT MAINTENANCE & REPAIR		5,908	
	ELEVATOR MAINTENANCE & REPAIR			
	OUTSIDE LABOR			
	EXTERMINATING SERVICE		1,536	
	FIRE SERVICE			
				18,997
7	**OTHER**			
	SCAVENGER		7,832	
	SECURITY SERVICE			
				7,832
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,000	6,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE			
	PURCHASED SERVICES			
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2		
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2		
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2		
	PHARMACY CONSULTANT	XVIII B 39-2	4,031	
	UTILIZATION REVIEW FEES	XVIII B __-2		
	PHYSICIANS	XVIII B __-2		
	PSYCHIATRIC	XVIII B __-2		
	RN CONSULTANT	XVIII B 38-2	3,908	
				7,939
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES			
	OCCUPATIONAL THERAPY SERVICES			
	REHABILITATION CONSULTANT	XVIII B __-2		
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2		
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2		
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2		
	SPEECH THERAPY CONSULTANT	XVIII B 43-2		
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	652	
				652
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2		
	SOCIAL WORKER	XVIII B 45-2	780	
				780
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII		0

Facility Name & ID Number PARK RIDGE CARE CENTER **#0039255** **Report Period Beginning: 01/01/2018** **Ending: 12/31/2018**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION			
				0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B		0
	DIRECTORS FEES			
18	DIRECTORS FEES			0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	6,362	
	ADMINISTRATIVE CONSULTANTS	XIX C		
	PROFESSIONAL FEES	XIX C	38,695	
				45,057
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F		
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	1,800	
	EMPLOYEE RECRUITMENT/WANT ADS	XIX F	3	
	CONTRIBUTIONS	VI 20 XIX F		
	DUES & SUBSCRIPTIONS	XIX F	5,438	
	LICENSES & PERMITS	XIX F	8,590	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F		
	ADVERTISING-YELLOW PAGES	VI 28 XIX F		
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F		
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	4,479	
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F		
	PATIENT BACKGROUND CHECKS	XIX F		
				20,310
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		3,060	
	EQUIPMENT REPAIR & MAINTENANCE		1,016	
	OUTSIDE CLERICAL SERVICES		36,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	1,178	
	HOME OFFICE EXPENSE			
	THEFT & DAMAGE LOSS			
	TELEPHONE		9,074	
	MESSENGER SERVICE			
				50,328

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	109,269	
	UNEMPLOYMENT COMPENSATION	XIX D	5,369	
	WORKERS COMPENSATION INSURANC	XIX D	28,638	
	HOSPITALIZATION INSURANCE	XIX D	27,062	
	EMPLOYEE BENEFITS - OTHER	XIX D	7,503	
	EMPLOYEE PHYSICAL EXAMS	XIX D		
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D		
	PENSION/PROFIT SHARING PLANS	XIX D		
				177,841
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		448	
				448
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G		
	TRAVEL	XIX G	4,193	
				4,193
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF			
				0
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		92,525	
				92,525
27	**OTHER**			
	BAD DEBTS	VI 24	158,841	
				158,841

GRAND TOTAL COLUMN 3 OTHER **627,508**

PARK RIDGE CARE CENTER
SCHEDULES
12/31/2018

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	66,905
LESS SALES TAX	(81)
NET FOOD	66,824
TOTAL PATIENT CENSUS	14,663
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	43,989
ADD # EMPLOYEE MEALS/DAY	6
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	2,190
PATIENT MEALS	43,989
ADD EMPLOYEE MEALS	2,190
TOTAL MEALS/YEAR	46,179
NET FOOD	66,824
DIVIDE TOTAL MEALS/YEAR	46,179
COST PER MEAL	1.45
TIMES EMPLOYEE MEALS	2,190
EMPLOYEE MEAL RECLASSIFIC	**3,176**

Facility Name & ID Number PARK RIDGE CARE CENTER #0039255 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			19,358	19,358		19,358	52,144	71,502			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							56,274	56,274			32
33	Real Estate Taxes							217,121	217,121			33
34	Rent-Facility & Grounds			385,000	385,000		385,000	(385,000)				34
35	Rent-Equipment & Vehicles			11,214	11,214		11,214	4,760	15,974			35
36	Other (specify):*							6,778	6,778			36
37	**TOTAL Ownership**			415,572	415,572		415,572	(47,923)	367,649			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		28,866	143,373	172,239		172,239		172,239			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			107,501	107,501		107,501		107,501			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		28,866	250,874	279,740		279,740		279,740			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,525,980	219,915	1,293,954	3,039,849		3,039,849	(139,842)	2,900,007			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 PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(12,321)	30		9
10	Interest and Other Investment Income	(1,754)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(81)	1		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	(1,178)	21		18
19	Entertainment				19
20	Contributions	(4,479)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(158,841)	27		24
25	Fund Raising, Advertising and Promotional	(1,800)	20		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	(32,614)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (213,068)		$	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)	73,226		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 73,226		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (139,842)		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

PARK RIDGE CARE CENTER

ID# 0039255

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Charges	$ (3,060)	21	1
2	Nonallowable Marketing Salary	(13,285)	17	2
3	Building Co. - Professional fees	(16,269)	19	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(32,614)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(81)	0	0	0	0	0	0	0	0	0	0	(81)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	511	0	0	0	0	0	0	0	0	511	5
6	Maintenance	0	0	2,859	0	0	0	0	0	0	0	0	2,859	6
7	Other (specify):*	0	0	348	0	0	0	0	0	0	0	0	348	7
8	**TOTAL General Services**	(81)	0	3,718	0	0	0	0	0	0	0	0	3,637	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(13,285)	0	0	42,421	0	0	0	0	0	0	0	29,136	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(16,269)	16,269	1,585	0	0	0	0	0	0	0	0	1,585	19
20	Fees, Subscriptions & Promotions	(6,279)	0	960	0	0	0	0	0	0	0	0	(5,319)	20
21	Clerical & General Office Expenses	(4,238)	0	1,584	5,480	0	0	0	0	0	0	0	2,826	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	238	0	0	0	0	0	0	0	0	238	24
25	Other Admin. Staff Transportation	0	0	2,488	0	0	0	0	0	0	0	0	2,488	25
26	Insurance-Prop.Liab.Malpractice	0	2,238	2,194	0	0	0	0	0	0	0	0	4,432	26
27	Other (specify):*	(158,841)	0	27,899	0	0	0	0	0	0	0	0	(130,942)	27
28	**TOTAL General Administration**	(198,912)	18,507	36,948	47,901	0	0	0	0	0	0	0	(95,556)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(198,993)	18,507	40,666	47,901	0	0	0	0	0	0	0	(91,919)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	(12,321)	63,403	1,062	0	0	0	0	0	0	0	0	52,144	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,754)	57,078	950	0	0	0	0	0	0	0	0	56,274	32
33	Real Estate Taxes	0	215,074	2,047	0	0	0	0	0	0	0	0	217,121	33
34	Rent-Facility & Grounds	0	(385,000)	0	0	0	0	0	0	0	0	0	(385,000)	34
35	Rent-Equipment & Vehicles	0	0	4,760	0	0	0	0	0	0	0	0	4,760	35
36	Other (specify):*	0	6,778	0	0	0	0	0	0	0	0	0	6,778	36
37	**TOTAL Ownership**	(14,075)	(42,667)	8,819	0	0	0	0	0	0	0	0	(47,923)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(213,068)	(24,160)	49,485	47,901	0	0	0	0	0	0	0	(139,842)	45

Facility Name & ID Number PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 SUPP		SEE PAGE 6 SUPP		SEE PAGE 6 SUPP		

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	Rental Income	$ 385,000	665 Busse Highway Limited Partnership	100.00%	$	$ (385,000)	1
2	V	32	Amortization- loan costs		665 Busse Highway Limited Partnership	100.00%	1,645	1,645	2
3	V	32	Interest Expense-Mortgage		665 Busse Highway Limited Partnership	100.00%	55,433	55,433	3
4	V	30	Depreciation		665 Busse Highway Limited Partnership	100.00%	63,403	63,403	4
5	V	36	Mip Insurance		665 Busse Highway Limited Partnership	100.00%	6,778	6,778	5
6	V	33	Real Estate Tax		665 Busse Highway Limited Partnership	100.00%	215,074	215,074	6
7	V	26	Insurance		665 Busse Highway Limited Partnership	100.00%	2,238	2,238	7
8	V	19	Professional Fees		665 Busse Highway Limited Partnership	100.00%	16,269	16,269	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 385,000			$ 360,840	$ * (24,160)	14

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

Facility Name & ID Number PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Outside Clerical	$ 36,000	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$	$ (36,000)	15
16	V	5	UTILITIES		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	511	511	16
17	V	6	REPAIR & MAINT. - SALARIES		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	608	608	17
18	V	6	REPAIR & MAINT.-OTHER EXPENSE		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	2,251	2,251	18
19	V	7	EMP BEN-GEN SERV		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	348	348	19
20	V	19	PROFESSIONAL FEES		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	1,585	1,585	20
21	V	20	DUES AND SUBSCRIPTION		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	960	960	21
22	V	21	CLERICAL & GENERAL - SALARIES		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	27,831	27,831	22
23	V	21	CLERICAL & GENERAL-OTHER EXPENSE		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	9,753	9,753	23
24	V	24	SEMINARS AND TRAVEL		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	238	238	24
25	V	25	AUTO EXPENSE		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	2,488	2,488	25
26	V	26	INSURANCE		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	2,194	2,194	26
27	V	27	EMP. BEN. - GEN, ADMIN.		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	27,899	27,899	27
28	V	30	DEPRECIATION		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	1,062	1,062	28
29	V	32	INTEREST		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	950	950	29
30	V	33	REAL ESTATE TAXES		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	2,047	2,047	30
31	V	35	AUTO RENTAL		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	4,475	4,475	31
32	V	35	EQUIPMENT RENTAL		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	285	285	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 36,000			$ 85,485	$ * 49,485	39

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

Facility Name & ID Number PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	6	MAINT COMP - D NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$	$	15
16	V	17	ADMIN COMP - M MAUER		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	8,350	8,350	16
17	V	17	ADMIN COMP - M AARON		DYNAMIC HEALTHCARE CONSULTANTS	100.00%			17
18	V	17	ADMIN COMP - F AARON		DYNAMIC HEALTHCARE CONSULTANTS	100.00%			18
19	V	17	ADMIN COMP - D AARON		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	3,470	3,470	19
20	V	17	ADMIN COMP - S GOLDSTEIN		DYNAMIC HEALTHCARE CONSULTANTS	100.00%			20
21	V	17	ADMIN COMP - R AARON		DYNAMIC HEALTHCARE CONSULTANTS	100.00%			21
22	V	17	ADMIN COMP - S HARAMARAS		DYNAMIC HEALTHCARE CONSULTANTS	100.00%			22
23	V	17	ADMIN COMP - D KUFTA		DYNAMIC HEALTHCARE CONSULTANTS	100.00%			23
24	V	17	ADMIN COMP - HOWARD ALTER		DYNAMIC HEALTHCARE CONSULTANTS	100.00%			24
25	V	17	ADMIN COMP - NON OWNER - V DAVIS		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	8,982	8,982	25
26	V	17	ADMIN COMP - VAR NON OWNER		DYNAMIC HEALTHCARE CONSULTANTS	100.00%			26
27	V	17	ADMIN COMP - CFO NON OWNER		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	14,686	14,686	27
28	V	17	ADMIN COMP - CONTROLLER-NON OWNER		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	6,933	6,933	28
29	V	21	CLERICAL COMP - S AARON		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	5,480	5,480	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			$			$ 47,901	$ * 47,901	39

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

Facility Name & ID Number PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	Freida Mauer	50.00%	Bridgeview Health Care Center	Bridgeview	665 Busse Highway Limited Partnership		Building Company	1
2	Joseph Mauer	25.00%	Grosse Pointe Manor	Niles	Dynamic Healthcare	Skokie	Bookkeeping/Consu	2
3	Sprintza Mauer	25.00%	Ottawa Pavillion Ltd	Ottawa	Seasons Hospice	Park Ridge	Hospice	3
4			Sterling Pavilion Ltd	Sterling	Lifeline Ambulance	Chicago	Ambulance	4
5			Waterfront Terrace Inc	Chicago				5
6			Willow Crest Nursing Pavilion Ltd	Sandwich				6
7			Windmill Nursing Pavilion Ltd	South Holland				7
8			Woodbridge Nursing Pavilion Ltd	Chicago				8
9			Woodbridge Supportive Living Residence of Ga	Galesberg				9
10			Woodbridge Supportive Living Residence of Ga	Galesberg				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 PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	Marshall Mauer	Relative	Administrative		See Attached			Salary	$ 8,350	17-07	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 8,350		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 PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

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 PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

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: DYNAMIC HEALTH CARE CONSULTANTS
Street Address: 3359 W MAIN STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	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	302,492	10	$ 10,544	$	14,663	$ 511	1
2	6	REPAIR & MAINT. - SALARIES	PATIENT DAYS	302,492	10	12,541	12,541	14,663	608	2
3	6	REPAIR & MAINT.-OTHER EXPE	PATIENT DAYS	302,492	10	46,430		14,663	2,251	3
4	7	EMP BEN-GEN SERV	PATIENT DAYS	302,492	10	7,174		14,663	348	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	302,492	10	32,693		14,663	1,585	5
6	20	DUES AND SUBSCRIPTION	PATIENT DAYS	302,492	10	19,807		14,663	960	6
7	21	CLERICAL & GENERAL - SALARI	PATIENT DAYS	302,492	10	574,139	574,139	14,663	27,831	7
8	21	CLERICAL & GENERAL-OTHER I	PATIENT DAYS	302,492	10	201,196		14,663	9,753	8
9	24	SEMINARS AND TRAVEL	PATIENT DAYS	302,492	10	4,903		14,663	238	9
10	25	AUTO EXPENSE	PATIENT DAYS	302,492	10	51,327		14,663	2,488	10
11	26	INSURANCE	PATIENT DAYS	302,492	10	45,267		14,663	2,194	11
12	27	EMP. BEN. - GEN, ADMIN.	PATIENT DAYS	302,492	10	575,549		14,663	27,899	12
13	30	DEPRECIATION	PATIENT DAYS	302,492	10	21,903		14,663	1,062	13
14	32	INTEREST	PATIENT DAYS	302,492	10	19,599		14,663	950	14
15	33	REAL ESTATE TAXES	PATIENT DAYS	302,492	10	42,234		14,663	2,047	15
16	35	AUTO RENTAL	PATIENT DAYS	302,492	10	92,319		14,663	4,475	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	302,492	10	5,875		14,663	285	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,763,500	$ 586,680		$ 85,485	25

Facility Name & ID Number PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

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: DYNAMIC HEALTH CARE CONSULTANTS
Street Address: 3359 W MAIN STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT COMP - D NEHMER	WGHTD AVG HOURS	40	7	$ 60,778	$ 60,778		$	1
2	17	ADMIN COMP - M MAUER	WGHTD AVG HOURS	40	10	200,000	200,000	2	8,350	2
3	17	ADMIN COMP - M AARON	WGHTD AVG HOURS	40	7	200,000	200,000			3
4	17	ADMIN COMP - F AARON	WGHTD AVG HOURS	45	5	2,500	2,500			4
5	17	ADMIN COMP - D AARON	WGHTD AVG HOURS	30	10	76,541	76,541	1	3,470	5
6	17	ADMIN COMP - S GOLDSTEIN	WGHTD AVG HOURS	40	2	159,922	159,922			6
7	17	ADMIN COMP - R AARON	WGHTD AVG HOURS	30	5	26,000	26,000			7
8	17	ADMIN COMP - S HARAMARAS	WGHTD AVG HOURS	30	3	69,011	69,011			8
9	17	ADMIN COMP - D KUFTA	WGHTD AVG HOURS	40	7	156,522	156,522			9
10	17	ADMIN COMP - HOWARD ALTER	WGHTD AVG HOURS	40	1	12,000	12,000			10
11	17	ADMIN COMP - NON OWNER - V	WGHTD AVG HOURS	40	9	132,083	132,083	3	8,982	11
12	17	ADMIN COMP - VAR NON OWNEI	WGHTD AVG HOURS	45	7	36,458	36,458			12
13	17	ADMIN COMP - CFO NON OWNEI	WGHTD AVG HOURS	40	9	215,972	215,972	3	14,686	13
14	17	ADMIN COMP - CONTROLLER-N	WGHTD AVG HOURS	40	9	101,958	101,958	3	6,933	14
15	21	CLERICAL COMP - S AARON	WGHTD AVG HOURS	40	9	80,583	80,583	3	5,480	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,530,328	$ 1,530,328		$ 47,901	25

Facility Name & ID Number PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	Midland Bank		X	Mortgage			$	$ 1,218,263			$ 55,433	1
2												2
3	Loan Costs	X		Loan Costs	W/O OVER LOAN		44,965	39,481			1,645	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 44,965	$ 1,257,744			$ 57,078	9
	B. Non-Facility Related*											
10	Interest Income		x								(1,754)	10
11	Allocated from Dynamic HC										950	11
12	Interest Income Bldg Co		x									12
13												13
14	TOTAL Non-Facility Related						$	$			$ (804)	14
15	TOTALS (line 9+line14)						$ 44,965	$ 1,257,744			$ 56,274	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 6,778 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 PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	180,000	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.)	$	197,621	2
3. Under or (over) accrual (line 2 minus line 1).	$	17,621	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	199,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	217,121	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	178,350	8
	2014	188,287	9
	2015	192,074	10
	2016	172,663	11
	2017	195,574	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PARK RIDGE CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0039255

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-27-213-053-0000	Long Term Care Property	$ 195,574.34	$ 195,574.34
2.	10-23-404-059-0000	Allocated from Dynamic	$ 42,234.00	$ 2,047.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 237,808.34	$ 197,621.34

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 13,300 B. General Construction Type: Exterior Brick Frame Steel Stud Number of Stories 1

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).

N/A

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 49,000	1
2					2
3	TOTALS			$ 49,000	3

Facility Name & ID Number PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	46		1986	1986	$ 1,323,000	$ 63,403	39	$ 33,923	$ (29,480)	$ 849,489	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1994	8,310		20			8,310	9
10	Various			1995	33,691		20			33,691	10
11	Various			1997	21,547		20	540	540	21,303	11
12	Various			1998	18,893		20	719	719	18,893	12
13	Various			1999	7,527		20	376	376	7,329	13
14	Various			2000	68,323		20	3,376	3,376	62,516	14
15	Various			2001	3,525		20	81	81	3,301	15
16	Various			2002	5,638		20	185	185	4,991	16
17	Various			2003	24,130		20	350	350	22,501	17
18	Various			2004	3,490		20	175	175	2,522	18
19	Various			2005	1,858		20	93	93	1,249	19
20	Various			2006	6,500		20	325	325	3,983	20
21	Various			2008	11,545		20	573	573	9,135	21
22	Various			2010	6,813		20	273	273	2,330	22
23	Various			2011	11,965		20	307	307	2,233	23
24	Various			2012	25,060		20	643	643	4,321	24
25	Various			2013	5,920		20	152	152	892	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 PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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									67
68									68
69	Financial Statement Depreciation			19,358			(19,358)		69
70	TOTAL (lines 4 thru 69)		$ 1,587,735	$ 82,761		$ 42,091	$ (40,670)	$ 1,058,989	70

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

Facility Name & ID Number PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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		$ 1,587,735	$ 82,761		$ 42,091	$ (40,670)	$ 1,058,989	1
2	Security cameras	2014	2,580		20	369	369	1,690	2
3	Remodeling supplies - window installation	2014	2,760		20	552	552	2,392	3
4	Tuckpointing/painting	2014	5,000		20	100	100	3,433	4
5	Install fire prevention device	2015	4,300		20	123	123	461	5
6	Repair leaking pipes above corridor ceiling	2016	2,988		20	149	149	423	6
7	Blinds for resident rooms	2017	3,300		20	31	31	62	7
8	New piping and sod exterior	2017	4,392		20	10	10	20	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)		$ 1,613,055	$ 82,761		$ 43,425	$ (39,336)	$ 1,067,470	34

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

Facility Name & ID Number PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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		$ 1,613,055	$ 82,761		$ 43,425	$ (39,336)	$ 1,067,470	1
2	Building Company								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Flooring	2008	14,000		20	700	700	8,983	9
10	Nursing station	2008	5,000		20	250	250	3,167	10
11	Nursing station	2008	4,700		20	235	235	2,977	11
12	Econocare call light system	2008	12,011		20	601	601	8,011	12
13	Jacks & Son asphalt parking lot	2008	16,033		20	802	802	9,890	13
14	Flooring	2008	14,000		20	779	779	9,348	14
15	Drop ceiling & lighting	2009	19,000		20	950	950	11,083	15
16	Roof rubber installation	2009	3,000		20	150	150	1,675	16
17	Lobby - Wallpaper, vinyl time, millwork, cove base	2010	4,185		20	209	209	1,881	17
18	Conference room - wallpaper, vinyl tile, millwork, cove base	2010	3,909		20	195	195	1,755	18
19	Corridor - wallpaper, vinyl tile, millwork, cove base	2010	19,821		20	991	991	8,919	19
20	Various areas: wallcovering, vinyl floor, paint (doors, frames)	2010	48,069		20	2,403	2,403	21,628	20
21	Door	2011	11,077		20	554	554	4,432	21
22	Double entry kithcen door	2011	3,450		20	173	173	1,384	22
23	Built in cabinet and countertop	2011	6,775		20	339	339	2,712	23
24	Remodeling of 2 bathrooms	2013	19,965		20	998	998	4,990	24
25	Roof replacement	2013	14,300		20	715	715	3,575	25
26	Remove/replace floor tile with ceramic tile in kitchen	2013	5,875		20	294	294	1,176	26
27	Kitchen hood	2015	14,500		20	725	725	2,900	27
28	Remove/replace basement walls	2015	11,875		20	594	594	2,376	28
29	Kitchen floor tile, replace pipes, countertop	2015	32,681		20	1,634	1,634	6,536	29
30	Patio and sidewalk concrete work	2015	5,500		20	275	275	825	30
31	Roof repairs	2016	22,900		20	1,145	1,145	3,435	31
32	Window replacement	2016	14,869		20	929	929	2,787	32
33	Gutters and downspouts	2016	3,495		20	175	175	525	33
34	TOTAL (lines 1 thru 33)		$ 1,944,045	$ 82,761		$ 60,240	$ (22,521)	$ 1,194,440	34

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

Facility Name & ID Number PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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		$ 1,944,045	$ 82,761		$ 60,240	$ (22,521)	$ 1,194,440	1
2	Tuckpointing, sidewalk replacement, paint front porch, entrance								2
3	Laundry room, kitchen, resident bathroom, new ramp handrail	2017	42,800		20	2,140	2,140	4,284	3
4	Replace metal door in basement, install electrical panel door locks	2017	2,768		20	138	138	276	4
5	Window repair in basement - thermal treatement	2017	4,217		20	211	211	422	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
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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)		$ 1,993,830	$ 82,761		$ 62,729	$ (20,032)	$ 1,199,422	34

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

Facility Name & ID Number PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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		$ 1,993,830	$ 82,761		$ 62,729	$ (20,032)	$ 1,199,422	1
2									2
3									3
4	Related Party								4
5	Buildings:								5
6	Allocated from dynamic healthcare consulting	1993	21,248	558	35	607	49	15,380	6
7									7
8									8
9									9
10									10
11	Leasehold improvements:								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)		$ 2,015,078	$ 83,319		$ 63,336	$ (19,983)	$ 1,214,802	34

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

Facility Name & ID Number PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 55,547	$	$ 7,233	$ 7,233	10	$ 50,527	71
72	Current Year Purchases	6,473		324	324	10	324	72
73	Fully Depreciated Assets	283,192	344	13	(331)	10	283,166	73
74								74
75	TOTALS	$ 345,212	$ 344	$ 7,570	$ 7,226		$ 334,017	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 Dynamic Healthcare		$ 13,853	$ 160	$ 596	$ 436		$ 11,886	76
77										77
78										78
79										79
80	TOTALS			$ 13,853	$ 160	$ 596	$ 436		$ 11,886	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)	$ 2,423,143	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 83,823	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 71,502	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (12,321)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,560,705	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 PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 3,092 Description: PRINTERS / COPIER
(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	Facility	2015 Buick Enclave	$	$ 8,122	17
18	Allocated Dynamic Hc Consultants				18
19					19
20					20
21	TOTAL		$	$ 8,122	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 PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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.

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	$		$ 66,941	$		$ 66,941	1
2	Licensed Speech and Language Development Therapist	39-03	hrs			1,734			1,734	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03	hrs			73,878			73,878	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				25,419		25,419	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):	39-03				820			820	12
13	MED.SUPPLIES/LAB/RADIOLOGY Other (specify):	39-02					3,447		3,447	13
14	TOTAL			$		$ 143,373	$ 28,866		$ 172,239	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 PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018 (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	$ 545,934	$ 614,969	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 496,000)	288,611	288,611	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	53,960	60,040	6
7	Other Prepaid Expenses	16,106	16,106	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): employee loans, escrows	11,150	305,891	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 915,761	$ 1,285,617	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		49,000	13
14	Buildings, at Historical Cost		1,323,000	14
15	Leasehold Improvements, at Historical Cost	405,471	677,786	15
16	Equipment, at Historical Cost	205,696	402,586	16
17	Accumulated Depreciation (book methods)	(451,555)	(1,671,826)	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 (spe dep on fixed assets	62,945	62,945	22
23	Other(specify): loan costs		39,481	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 222,557	$ 882,972	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,138,318	$ 2,168,589	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 144,607	$ 143,579	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,960	6,960	28
29	Short-Term Notes Payable	183,993	189,741	29
30	Accrued Salaries Payable	178,719	178,719	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,879	5,879	31
32	Accrued Real Estate Taxes(Sch.IX-B)		199,500	32
33	Accrued Interest Payable		4,568	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 520,158	$ 728,946	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,187,515	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 1,187,515	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 520,158	$ 1,916,461	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 618,160	$ 252,128	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,138,318	$ 2,168,589	48

*(See instructions.)

Facility Name & ID Number PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 735,050	1
2	Restatements (describe):		2
3	ROUNDING	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 735,052	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(56,892)	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	(60,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) OUT OF PERIOD EXPENSES		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (116,892)	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)**	$ 618,160	24 *

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

Facility Name & ID Number PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 2,904,968	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,904,968	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	65,303	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 65,303	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,754	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,754	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)**	$ 2,972,025	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	523,139	31
32	Health Care	1,109,907	32
33	General Administration	711,491	33
	B. Capital Expense		
34	Ownership	415,572	34
	C. Ancillary Expense		
35	Special Cost Centers	172,239	35
36	Provider Participation Fee	107,501	36
	D. Other Expenses (specify):		
37	**Prior Year Expense**	(11,299)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,028,550	40
41	**Income before Income Taxes (line 30 minus line 40)****	(56,525)	41
42	**Income Taxes**	(367)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (56,892)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,250,198	44
45	Private Pay - Net Inpatient Revenue	15,172	45
46	Medicare - Net Inpatient Revenue	639,598	46
47	Other-(specify) **HOSPICE/INSURANCE/ETC**		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,904,968	49

TAX RETURN HAS NOT BEEN PREPARED AS OF COST REPORT FILING

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

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

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

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

Facility Name & ID Number PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	5,182	5,351	$ 223,865	$ 41.84	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,811	7,189	237,505	33.04	3
4	Licensed Practical Nurses	1,481	1,529	36,156	23.65	4
5	CNAs & Orderlies	30,327	32,494	471,603	14.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,965	2,102	45,334	21.57	9
10	Activity Assistants	1,842	1,946	22,835	11.73	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,468	2,635	61,590	23.37	13
14	Head Cook	4,173	4,534	71,549	15.78	14
15	Cook Helpers/Assistants	3,408	3,472	43,988	12.67	15
16	Dishwashers					16
17	Maintenance Workers	1,925	2,086	47,478	22.76	17
18	Housekeepers	6,293	6,574	80,092	12.18	18
19	Laundry	2,379	2,492	30,170	12.11	19
20	Administrator	2,086	2,271	132,852	58.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,048	1,176	20,963	17.83	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	71,388	75,851	$ 1,525,980 *	$ 20.12	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 50	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	3,908	10-3	38
39	Pharmacist Consultant	H	4,031	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	652	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 14,641		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rob Weisz	ADMINISTRATOR		$ 132,852
			0
			0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 132,852

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
MARCUM LLP	ACCOUNTING	$ 15,602
HDSI	DATA PROCESSING	4,371
POINT CLICKCARE	DATA PROCESSING	1,991
PERSONNEL PLANNERS	UNEMPLOY TAX CONS	660
TERRILL CONSUL SERVICES	MDS CONSULTING	6,331
STOUT RISIUS ROSS LLC	FINANCIAL CONSULT	5,000
S4 GROUP	HEALTHCARE CONSULT	6,000
R/E ANALYSIS CORP	R/E APPRAISAL	4,000
		203
MUCH SHELIST	LEGAL	899
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 45,057

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 28,638
Unemployment Compensation Insurance	5,369
FICA Taxes	109,269
Employee Health Insurance	27,062
Employee Meals	3,176
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits Other	7,503
	0
	0
	0
	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 181,017

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3
Health Care Worker Background Check	0
(Indicate # of checks performed)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	4,479
MARKETING/ADV/PROMO	1,800
LICENSES/DUES/SUBSCRIPTIONS	14,028
MGMT CO ALLOC	960
TRUST/FRANCHISE/CONTRIB/ETC	(4,479)
Less: Public Relations Expense	(0)
Non-allowable advertising	(1,800)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,991

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,193
Seminar Expense	0
Allocated from Dynamic Healthcare	238
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,431

* Attach copy of IMRF notifications

**See instructions.

PARK RIDGE CARE CENTER
LEGAL EXPENSES
12/31/2018

DATE	FIRM	INVOICE #	PURPOSE	COST

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. **Health Care Council of Illinois 7,958**

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 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.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **107,501**
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? If YES, attach an explanation of the allocation.

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **3,176** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

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

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