		FOR BHF USE					

LL1

IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0051862

Facility Name: OAKRIDGE HEALTHCARE CENTER

Address: 323 OAKRIDGE AVENUE (Number) HILLSIDE (City) 60162 (Zip Code)

County: COOK

Telephone Number: (708) 547-6595 **Fax #** (708) 547-1971

HFS ID Number:

Date of Initial License for Current Owners: 01/01/12

Type of Ownership:

VOLUNTARY,NON-PROFIT	PROPRIETARY	GOVERNMENTAL
[ ] 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: 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 1/1/2020 to 12/31/2020 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)	ELI ATKIN
	(Title)	ADMINISTRATOR
Paid Preparer	(Signed)	(SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
	(Print Name and Title)	KATHLEEN MCNAMARA VICE-PRESIDENT
	(Firm Name & Address)	KBKB, LTD 6201 W. HOWARD STREET SUITE 201, NILES, IL 60714
	(Telephone)	(847) 675-3585 Fax # (847) 675-3585

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 OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	58	Skilled (SNF)	58	21,228	1
2		Skilled Pediatric (SNF/PED)			2
3	15	Intermediate (ICF)	15	5,490	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	73	TOTALS	73	26,718	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		796	3,483	4,279	8
9	SNF/PED					9
10	ICF	14,140		39	14,179	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,140	796	3,522	18,458	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.08%

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 1/1/12

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 58 and days of care provided 3,483

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: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	184,812	40,079	7,157	232,048		232,048		232,048			1
2	Food Purchase		137,609		137,609		137,609		137,609			2
3	Housekeeping	168,253	34,910		203,163		203,163		203,163			3
4	Laundry	41,882	26,366		68,248		68,248		68,248			4
5	Heat and Other Utilities			124,230	124,230		124,230		124,230			5
6	Maintenance	49,944	20,499	48,933	119,376		119,376		119,376			6
7	Other (specify):*			9,109	9,109		9,109		9,109			7
8	TOTAL General Services	444,891	259,463	189,429	893,783		893,783		893,783			8
	B. Health Care and Programs											
9	Medical Director			11,200	11,200		11,200		11,200			9
10	Nursing and Medical Records	1,387,726	99,847	5,930	1,493,503		1,493,503		1,493,503			10
10a	Therapy	115,312	60	272	115,644		115,644		115,644			10a
11	Activities	95,604	4,579		100,183		100,183		100,183			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation			880	880		880		880			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,598,642	104,486	18,282	1,721,410		1,721,410		1,721,410			16
	C. General Administration											
17	Administrative	100,779		42,848	143,627		143,627	5,967	149,594			17
18	Directors Fees											18
19	Professional Services			183,923	183,923		183,923		183,923			19
20	Dues, Fees, Subscriptions & Promotions			41,969	41,969		41,969	(13,352)	28,617			20
21	Clerical & General Office Expenses	73,175	10,019	613,875	697,069		697,069	(524,732)	172,337			21
22	Employee Benefits & Payroll Taxes			296,297	296,297		296,297		296,297			22
23	Inservice Training & Education			2,438	2,438		2,438		2,438			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			6,975	6,975		6,975		6,975			25
26	Insurance-Prop.Liab.Malpractice			240,245	240,245		240,245		240,245			26
27	Other (specify):*			171,172	171,172		171,172	(171,172)				27
28	TOTAL General Administration	173,954	10,019	1,599,742	1,783,715		1,783,715	(703,289)	1,080,426			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,217,487	373,968	1,807,453	4,398,908		4,398,908	(703,289)	3,695,619			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# OAKRIDGE HEALTHCARE CENTER #0051862 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	3,692	
	REPAIRS & MAINTENANCE		0	
	OUTSIDE SERVICES		3,465	
				7,157
3	**HOUSEKEEPING**			
	CONTRACTED HOUSEKKEEPING SERVICES		0	
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
	CONTRACTED LAUNDRY SERVICES		0	
				0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		20,111	
	ELECTRICITY		26,069	
	WATER		72,937	
	CABLE TV - LOBBY		5,113	
				124,230
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		550	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		7,750	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		18,666	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,367	
	FIRE SERVICE		19,600	
				48,933
7	**OTHER**			
	SCAVENGER		9,109	
	SECURITY SERVICE		0	
				9,109
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES		11,200	11,200

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		100	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	5,830	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
				5,930
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	272	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				272
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
				0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
				0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID# OAKRIDGE HEALTHCARE CENTER #0051862 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

V.COST CENTER EXPENSES

PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		880	
				880
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	42,848	42,848
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	66,245	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	117,678	
	BOOKKEEPING/ADMINISTRATIVE SERVICES		0	
				183,923
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F		
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	135	
	EMPLOYEE WANT ADS	XIX F	18,097	
	CONTRIBUTIONS	VI 20 XIX F	13,217	
	DUES & SUBSCRIPTIONS	XIX F	6,084	
	LICENSES & PERMITS	XIX F	2,284	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	144	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F	2,008	
	PATIENT BACKGROUND CHECKS	XIX F	0	
				41,969
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		36,526	
	EQUIPMENT REPAIR & MAINTENANCE		2,637	
	OUTSIDE CLERICAL SERVICES		529,482	
	PENALTIES / OVERDRAFT CHARGES	VI 18	25,018	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		163	
	TELEPHONE		20,049	
	MESSENGER SERVICE		0	
				613,875

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	173,274	
	UNEMPLOYMENT COMPENSATION	XIX D	10,245	
	WORKERS COMPENSATION INSURANCE	XIX D	48,864	
	HOSPITALIZATION INSURANCE	XIX D	56,931	
	EMPLOYEE BENEFITS - OTHER	XIX D	6,983	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
				296,297
23	INSERVICE TRAINING & EDUCATION			
	EDUCATION & SEMINARS		2,438	
				2,438
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G		
	TRAVEL	XIX G		
				0
25	ADMIN. STAFF TRANSPORTATION			
	TRANSPORTATION - STAFF		6,975	
				6,975
26	INSURANCE - PROP. LIAB & MALPRACTICE			
	GENERAL INSURANCE		240,245	
				240,245
27	**OTHER**			
	BAD DEBTS	VI 24	171,172	
				171,172

GRAND TOTAL COLUMN 3 OTHER **1,807,453**

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER #0051862 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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			8,221	8,221		8,221	51,681	59,902			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			79,021	79,021		79,021	294,206	373,227			32
33	Real Estate Taxes							238,726	238,726			33
34	Rent-Facility & Grounds			502,668	502,668		502,668	(502,668)				34
35	Rent-Equipment & Vehicles			44,026	44,026		44,026		44,026			35
36	Other (specify):*											36
37	TOTAL Ownership			633,936	633,936		633,936	81,945	715,881			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		55,015		55,015		55,015		55,015			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			108,062	108,062		108,062		108,062			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		55,015	108,062	163,077		163,077		163,077			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,217,487	428,983	2,549,451	5,195,921		5,195,921	(621,344)	4,574,577			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 OAKRIDGE HEALTHCARE CENTER **#** 0051862 **Report Period Beginning:** 1/1/2020 **Ending:** 12/31/2020

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	1,136	30		9
10	Interest and Other Investment Income	(4,182)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(25,018)	21		18
19	Entertainment		20		19
20	Contributions	(13,217)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(171,172)	27		24
25	Fund Raising, Advertising and Promotional	(135)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5A	(15,117)	22		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (227,705)		$	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)	(393,639)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (393,639)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (621,344)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

OAKRIDGE HEALTHCARE CENTER

ID# 0051862

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARIES	$ (15,117)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(15,117)		49

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	5,967	0	0	0	0	0	0	0	0	5,967	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(13,352)	0	0	0	0	0	0	0	0	0	0	(13,352)	20
21	Clerical & General Office Expenses	(40,135)	0	(484,597)	0	0	0	0	0	0	0	0	(524,732)	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	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(171,172)	0	0	0	0	0	0	0	0	0	0	(171,172)	27
28	**TOTAL General Administration**	(224,659)	0	(478,630)	0	0	0	0	0	0	0	0	(703,289)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(224,659)	0	(478,630)	0	0	0	0	0	0	0	0	(703,289)	29

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 **Report Period Beginning:** 1/1/2020 **Ending:** 12/31/2020

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

	Capital Expense D. Ownership	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)	
30	Depreciation	1,136	50,545	0	0	0	0	0	0	0	0	0	51,681	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,182)	298,388	0	0	0	0	0	0	0	0	0	294,206	32
33	Real Estate Taxes	0	238,726	0	0	0	0	0	0	0	0	0	238,726	33
34	Rent-Facility & Grounds	0	(502,668)	0	0	0	0	0	0	0	0	0	(502,668)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(3,046)	84,991	0	0	0	0	0	0	0	0	0	81,945	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)**	(227,705)	84,991	(478,630)	0	0	0	0	0	0	0	0	(621,344)	45

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 ATTACHED 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	RENT	$ 502,668	OAKRIDGE NURSING & REHAB PROPERTIES LLC		$	$ (502,668)	1
2	V								2
3	V	30	DEPRECIATION				50,545	50,545	3
4	V	32	INTEREST				285,962	285,962	4
5	V	33	REAL ESTATE TAXES				238,726	238,726	5
6	V	32	AMORT LOAN COSTS				12,426	12,426	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 502,668			$ 587,659	$ * 84,991	14

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

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 529,482	INNOVATIVE MANAGEMENT COMPANY		$	$ (529,482)	15
16	V	17	MANAGEMENT FEES	42,848				(42,848)	16
17	V								17
18	V								18
19	V	17	ADMINISTRATION-ELI ATKIN				7,891	7,891	19
20	V	17	ADMINISTRATION-JOEL ATKIN				3,944	3,944	20
21	V	21	CLERICAL-TZVI ATKIN				10,075	10,075	21
22	V	21	CLERICAL-SHULAMIT ATKIN				357	357	22
23	V	17	ADMINISTRATION-EMANUEL ATKIN				3,260	3,260	23
24	V	17	ADMINISTRATION-CEO				15,782	15,782	24
25	V	17	ADMINISTRATION-CFO				11,794	11,794	25
26	V	17	ADMINISTRATION CONTROLLER				6,144	6,144	26
27	V	17	ADMINISTRATION						27
28	V	21	CLERICAL				34,453	34,453	28
29	V	21	CLERICAL						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			$ 572,330			$ 93,700	$ * (478,630)	39

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

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	ELISHA ATKIN	50	WINDSOR ESTATE NURSING AND	TINLEY PARK	OAKRIDGE	HILLSIDE	REALTY	1
2	JYA ENTERPRISES LLC	50	REHAB		NURSING AND			2
3			ABINGTON OF GLRNVIEW NURSING	GLENVIEW	REHAB PROP, LLC			3
4			AND REHAB					4
5					MCALLISTER	TINLEY PARK	REALTY	5
6					PROPERTY,LLC			6
7								7
8					INNOVATIVE	MORTON GROVE	MANAGEMENT	8
9					MANAGEMENT			9
10					ASSOCIATES			10
11								11
12					ABINGTON OF	GLENVIEW	REALTY	12
13					GLENVIEW, PROP			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 OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	SHULAMIT ATRIN		ACCOUNTS RECEIVABLE		SEE ATTACHED	12.6	33.33	SALARY	$ 357	21-7	1
2					SCHEDULE						2
3	ELISHA ATKIN		ADMINISTRATIV	50.00		8.22	21.04	SALARY	7,891	17-7	3
4											4
5	EMANUEL ETKIN		ADMINISTRATIVE			8.22	21.04	SALARY	3,260	17-7	5
6											6
7	JOEL ATKIN		ADMINISTRATIVE			8.22	21.04	SALARY	3,944	17-7	7
8											8
9	TZVI (STEVE) ATKIN		PURCHASING			8.22	21.04	SALARY	10,075	21-7	9
10											10
11											11
12											12
13								TOTAL	$ 25,527		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 OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

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: INNOVATIVE MANAGEMENT COMPANY
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE ILL 60053
Phone Number: (708) 573-1100
Fax Number: (708) 573-1720

	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	17	ADMINISTRATION-ELI ATKIN	CENSUS DAYS	235,210	6	$ 100,556	$ 100,556	18,458	$ 7,891	1
2	17	ADMINISTRATION-JOEL ATKI	CENSUS DAYS	235,210	6	50,257	50,257	18,458	3,944	2
3	21	CLERICAL-TZVI ATKIN	CENSUS DAYS	235,210	6	128,387	128,387	18,458	10,075	3
4	21	CLERICAL-SHULAMIT ATKIN	CENSUS DAYS	235,210	6	4,550	4,550	18,458	357	4
5	17	ADMINISTRATION-EMANUEL	CENSUS DAYS	235,210	6	41,539	41,539	18,458	3,260	5
6	17	ADMINISTRATION-CEO	CENSUS DAYS	235,210	6	201,112	201,112	18,458	15,782	6
7	17	ADMINISTRATION-CFO	CENSUS DAYS	235,210	6	150,297	150,297	18,458	11,794	7
8	17	ADMINISTRATION CONTROLI	CENSUS DAYS	235,210	6	78,297	78,297	18,458	6,144	8
9	17	ADMINISTRATION	CENSUS DAYS	235,210	6	32,480	32,480		0	9
10	21	CLERICAL	CENSUS DAYS	235,210	6	439,036	439,036	18,458	34,453	10
11	21	CLERICAL	CENSUS DAYS	235,210	6	87,769	87,769		0	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					$ 1,314,280	$ 1,314,280		$ 93,700	25

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	RELATED PARTY						$	$			$	1
2	BANK LEUMI		X	MORTGAGE		12/27/12	3,000,000	3,000,000			280,668	2
3	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN		62,128	49,702			12,426	3
4	BANK LEUMI		X	CONSTRUCTION LOAN		10/31/14	100,000	5,234			5,294	4
5												5
	Working Capital											
6	GEMINO HC FINANCE		X	LINE OF CREDIT					REVOLV	PRIME+	47,813	6
7	VARIOUS MEMBERS	X		INTEREST ON CAPITAL							31,208	7
8												8
9	TOTAL Facility Related						$ 3,162,128	$ 3,054,936			$ 377,409	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,162,128	$ 3,054,936			$ 377,409	15

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

* 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 OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Item		Amount	Line
1. Real Estate Tax accrual used on 2019 report.	$	241,951	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.)	$	194,322	2
3. Under or (over) accrual (line 2 minus line 1).	$	(47,629)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	286,355	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.	$	238,726	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Year	Amount	Line
	2015	181,532	8
	2016	187,558	9
	2017	203,404	10
	2018	196,304	11
	2019	194,322	12

FOR BHF USE ONLY

Line	Item		Line
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.**

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME OAKRIDGE HEALTHCARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0051862

CONTACT PERSON REGARDING THIS REPORT KATHLEEN MCNAMARA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-17-413-052-0000	NURSING HOME	$ 95,901.36	$ 95,901.36
2.	15-17-413-067-0000	NURSING HOME	$ 98,420.51	$ 98,420.51
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 194,321.87	$ 194,321.87

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 18,970 B. General Construction Type: Exterior BRICK Frame CONCRETE WOOD Number of Stories 1

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

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (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				$	1
2	NURSING HOME	64,978	2009	225,000	2
3	TOTALS			$	3

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	73		2009		$ 1,295,561	$ 47,111	27.5	$ 47,111	$	$ 282,666	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VINYL PLANK FLOORING FOR 2 DINING ROOMS AND										9
10	HALLWAYS			2012	16,959	435	27.5	435		3,498	10
11	ROOF			2012	4,950	127	27.5	127		1,021	11
12	DRAPERIES, CORNICES, WINDOW TREATMENTS IN										12
13	RESIDENT ROOMS & PUBLIC AREA			2012	18,857		7	628	628	18,857	13
14	TILING AND FLOORING DONE IN 2 DINING ROOMS										14
15	AND HALLWAY			2013	11,200	287	39	287		2,141	15
16	LIGHTING IN ALL HALLWAYS THRUOUT BUILDING			2013	3,549	91	39	91		679	16
17	BASEBOARDS FOR DINING ROOMS AND HALLWAY			2013	7,900	203	39	203		1,514	17
18	VINYL			2013	8,899	228	39	228		1,701	18
19	SECURITY SYSTEM FOR PATIO, NURSES STATION,										19
20	FRONT LOBBY, 2 DINING ROOMS, ACTIVITY ROOM,										20
21	BREAK ROOM, 6 HALLWAYS, 2 BY BOILER ROOM,										21
22	1 OUTSIDE BY BACK ENTRANCE, AND 1 IN OFFICE										22
23	AREA			2013	11,314	290	39	290		2,163	23
24											24
25											25
26	HEATING BOILER			2013	12,800	328	39	328		2,446	26
27	NURSES STATION-OPEN CENTER OF EXISTING NURSES										27
28	STATION AND CLOSE OFF CURRENT OPEN AREA.										28
29	REPLACE EXISTING COUNTER TOP. INSTALL TILE. IN										29
30	HALLWAY, REMOVE ALL TILES, DRYWALL AND WORK										30
31	AROUND CEILING PIPING, INSTALL THE HANDRAIL										31
32	SKINS, WALL GUARDS. THERAPY ROOM- REMOVE										32
33	EXISTING WOOD PANEL THAT SITS UNDERNEATH										33
34	WALL VINYL. DRYWALL TOP PORTION AND PAINT.										34
35	REMOVE EXISTING FLOORING AND REPLACE WITH A										35
36	VINYL PLANK FLOORING			2013	21,300	546	39	546		4,072	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 OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	SALES TAX AND DELIVERY CHARGE ON VINYL		$	$		$	$	$	37
38	FLOORING, DRAPERIES, CORNICES, WINDOW								38
39	TREATMENTS, CHAIRS, AND BED THROWS	2013	7,084	182	39	182		1,357	39
40	RESILIENT FLOORING IN THE LOBBY AND IN THE								40
41	LIBRARY/CONFERENCE ROOM	2014	25,000	909	39	909		6,174	41
42	REMOVED AND REPLACED 3 PHASE DISCONNECT AND								42
43	CONTRO BOARD ON ROOF TOP UNIT. INSTALLED								43
44	NEW 5 TON GAS FIRED ROOF TOP UNIT, REMOVED								44
45	OLD UNIT	2014	10,168	370	39	370		2,513	45
46	PAINTING WALLS, CEILING, BATHROOM WALLS AND	2014	10,911		5			10,911	46
47	BATHROOM CEILINGS IN RESIDENT ROOMS								47
48	NUMBERED 1-22								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									69
70	TOTAL (lines 4 thru 69)		$ 1,466,452	$ 51,107		$ 51,735	$ 628	$ 341,713	70

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

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 79,877	$ 4,058	$ 7,987	$ 3,929	10 YRS	$ 49,149	71
72	Current Year Purchases	3,601	3,601	180	(3,421)	10 YRS	180	72
73	Fully Depreciated Assets							73
74	RELATED PARTY							74
75	TOTALS	$ 83,478	$ 7,659	$ 8,167	$ 508		$ 49,329	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,549,930	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 58,766	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 59,902	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,136	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 391,042	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY
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.		$
13.		$
14.		$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 44,026 Description: SCHEDULE ATTACHED
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	39-3	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				53,382		53,382	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): RADIOLOGY	39-2					1,633		0 1,633	13
14	TOTAL			$		$	$ 55,015		$ 55,015	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.

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (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	$ 388,512	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (403,594))	601,946		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	15,493		7
8	Accounts Receivable (owners or related parties)	779,591		8
9	Other(specify): Insurance Escrow deposit	200,000		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,985,542	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	21,909		15
16	Equipment, at Historical Cost	113,764		16
17	Accumulated Depreciation (book methods)	(114,460)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 21,213	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,006,755	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 411,001	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	320,758		29
30	Accrued Salaries Payable	90,628		30
31	Accrued Taxes Payable (excluding real estate taxes)	31,696		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO OAKRIDGE PROPERTIES	1,629,569		36
37	NOTE PAYABLE - SBA PPP LOAN	487,700		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,971,352	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	MEMBER'S LOANS PAYABLE	267,498		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 267,498	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,238,850	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,232,095)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,006,755	$	48

*(See instructions.)

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (951,243)	1
2	Restatements (describe):		2
3	PRIOR YEAR ADJUSTMENT	(734,172)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,685,415)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	453,120	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	200	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)**	$ 453,320	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)**	$ (1,232,095)	24 *

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

Facility Name & ID Number OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 4,101,058	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,101,058	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	187,300	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 187,300	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***	4,182	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,182	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	STIMULUS PAYMENT	1,203,391	28
28a	VENDING COMMISSIONS	288	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,203,679	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,496,219	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	893,783	31
32	Health Care	1,721,410	32
33	General Administration	1,783,715	33
	B. Capital Expense		
34	Ownership	633,936	34
	C. Ancillary Expense		
35	Special Cost Centers	55,015	35
36	Provider Participation Fee	108,062	36
	D. Other Expenses (specify):		
37	OTHER EXPENSE ADJUSTMENT	(152,822)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,043,099	40
41	**Income before Income Taxes (line 30 minus line 40)****	453,120	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 453,120	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,765,555	44
45	Private Pay - Net Inpatient Revenue	156,004	45
46	Medicare - Net Inpatient Revenue	442,085	46
47	Other-(specify) HOSPICE/INSURANCE/ETC	737,414	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,101,058	49

****TAX RETURN PREPARED ON CASH BASIS**

* 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 OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,955	2,239	$ 97,774	$ 43.67	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,321	10,108	336,463	33.29	3
4	Licensed Practical Nurses	8,689	9,144	272,743	29.83	4
5	CNAs & Orderlies	32,760	34,562	602,052	17.42	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,282	2,398	115,312	48.09	8
9	Activity Director					9
10	Activity Assistants	6,694	7,112	95,604	13.44	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,942	2,039	28,966	14.21	14
15	Cook Helpers/Assistants	10,894	11,452	155,846	13.61	15
16	Dishwashers					16
17	Maintenance Workers	1,938	2,091	49,944	23.89	17
18	Housekeepers	11,859	12,673	168,253	13.28	18
19	Laundry	2,773	2,854	41,882	14.67	19
20	Administrator	1,994	2,091	64,738	30.96	20
21	Assistant Administrator	2,150	2,306	36,041	15.63	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,347	2,760	73,175	26.51	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 C: Care Plan Coord	1,914	2,091	78,694	37.63	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	99,512	105,920	$ 2,217,487 *	$ 20.94	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 3,692	1-3	35
36	Medical Director	O	11,200	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	5,830	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		272	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	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)		$ 20,994		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	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 OAKRIDGE HEALTHCARE CENTER # 0051862 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
YAAKOV COHEN	ADMINISTRATOR	0	$ 64,738
DAVID VINITSKY	ASST ADMIN	0	36,041
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 100,779

B. Administrative - Other

Description	Amount
	$
MANAGEMENT FEES	42,848
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 42,848

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		183,923
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 183,923

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 48,864
Unemployment Compensation Insurance	10,245
FICA Taxes	173,274
Employee Health Insurance	56,931
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	6,983
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 296,297

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	$
Advertising: Employee Recruitment	18,097
Health Care Worker Background Check	2,008
(Indicate # of checks performed)	
Patient Background Checks	0
TRUST/FRANCHISE/CONTRIB/ETC	13,217
MARKETING/ADV/PROMO	279
LICENSES/DUES/SUBSCRIPTIONS	8,368
MGMT CO ALLOC	
TRUST/FRANCHISE/CONTRIB/ETC	(13,217)
Less: Public Relations Expense	(0)
Non-allowable advertising	(135)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,617

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

OAKRIDGE HEALTHCARE CENTER
SCHEDULE - LEGAL
12/31/2020

INVOICE DATE	FIRM NAME	DESCRIPTION OF SERVICE	AMOUNT
1/20/2020	ROBBINS SALOMON & PATT LTD	LEGAL SERVICES	21,389.00
9/25/2020	ROBBINS SALOMON & PATT LTD	LEGAL SERVICES	15,000.00
10/29/2020	ROBBINS SALOMON & PATT LTD	LEGAL SERVICES	20,000.00
11/20/2020	ROBBINS SALOMON & PATT LTD	LEGAL SERVICES	10,000.00
4/20/2020	GEMINO HC FINANCE	LINE OF CREDIT RENEWAL	13,355.72
	TOTAL		**79,744.72**

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? 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. $ 7,294 Line 10-2

(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 ____ 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. $ 108,062
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 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. $ 0 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 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.