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: 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 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) 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, 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 PARK RIDGE CARE CENTER # 0039255 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 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	16,836	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	16,836	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			1,983	1,983	8
9	SNF/PED					9
10	ICF	11,128	896		12,024	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,128	896	1,983	14,007	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.20%

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 1,983

Medicare Intermediary WISCONSIN PHYSICIANS SERVICE

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 PARK RIDGE CARE CENTER # 0039255 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	193,125	10,683		203,808		203,808		203,808			1
2	Food Purchase		63,682		63,682	(3,162)	60,520	(121)	60,399			2
3	Housekeeping	82,085	13,230		95,315		95,315		95,315			3
4	Laundry	37,251	12,344	375	49,970		49,970		49,970			4
5	Heat and Other Utilities			40,478	40,478		40,478	507	40,985			5
6	Maintenance	54,107	35,781	12,348	102,236		102,236	4,351	106,587			6
7	Other (specify):*			12,792	12,792		12,792		12,792			7
8	TOTAL General Services	366,568	135,720	65,993	568,281	(3,162)	565,119	4,737	569,856			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	984,919	115,910	6,322	1,107,151		1,107,151	5,492	1,112,643			10
10a	Therapy		50		50		50		50			10a
11	Activities	85,852	1,281	627	87,760		87,760		87,760			11
12	Social Services			132	132		132		132			12
13	CNA Training											13
14	Program Transportation			80	80		80		80			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,070,771	117,241	13,161	1,201,173		1,201,173	5,492	1,206,665			16
	C. General Administration											
17	Administrative	152,275		15,000	167,275		167,275	6,073	173,348			17
18	Directors Fees											18
19	Professional Services			61,781	61,781		61,781	12,494	74,275			19
20	Dues, Fees, Subscriptions & Promotions			24,229	24,229		24,229	(6,172)	18,057			20
21	Clerical & General Office Expenses	26,236	26,023	55,964	108,223		108,223	12,949	121,172			21
22	Employee Benefits & Payroll Taxes			201,248	201,248	3,162	204,410		204,410			22
23	Inservice Training & Education			1,354	1,354		1,354		1,354			23
24	Travel and Seminar			3,113	3,113		3,113	119	3,232			24
25	Other Admin. Staff Transportation							1,185	1,185			25
26	Insurance-Prop.Liab.Malpractice			213,948	213,948		213,948	7,101	221,049			26
27	Other (specify):*			120,000	120,000		120,000	(91,822)	28,178			27
28	TOTAL General Administration	178,511	26,023	696,637	901,171	3,162	904,333	(58,073)	846,260			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,615,850	278,984	775,791	2,670,625		2,670,625	(47,844)	2,622,781			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: 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	0	
	REPAIRS & MAINTENANCE		0	
	CONTRACTED DIETARY SERVICES		0	
				0
3	**HOUSEKEEPING**			
	CONTRACTED HOUSEKKEEPING SERVICES		0	
				0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		375	
	CONTRACTED LAUNDRY SERVICES		0	
				375
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		5,240	
	ELECTRICITY		20,639	
	WATER		10,700	
	CABLE TV - LOBBY		3,899	
				40,478
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		8,845	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		1,839	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,664	
	FIRE SERVICE		0	
				12,348
7	**OTHER**			
	SCAVENGER		12,792	
	SECURITY SERVICE		0	
				12,792
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES		6,000	6,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	3,410	
	LABORATORY & XRAY EXPENSE		0	
	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	2,912	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
				6,322
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 CONSULTAN	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	627	
				627
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	132	
				132
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID# PARK RIDGE CARE CENTER **#0039255 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		80	
				80
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	15,000	15,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	25,855	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	35,926	
	BOOKKEEPING/ADMINISTRATIVE SERVICES		0	
				61,781
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	2,000	
	EMPLOYEE WANT ADS	XIX F	1,586	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	4,143	
	LICENSES & PERMITS	XIX F	11,247	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	5,083	
	HEALTH CARE WORKER BACKGROUND CHECKS	XIX F		
	PATIENT BACKGROUND CHECKS	XIX F	170	
				24,229
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		3,391	
	EQUIPMENT REPAIR & MAINTENANCE		1,431	
	OUTSIDE CLERICAL SERVICES		45,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		6,142	
	MESSENGER SERVICE		0	
				55,964

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	114,231	
	UNEMPLOYMENT COMPENSATION	XIX D	5,862	
	WORKERS COMPENSATION INSURANCE	XIX D	34,263	
	HOSPITALIZATION INSURANCE	XIX D	26,416	
	EMPLOYEE BENEFITS - OTHER	XIX D	20,476	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
				201,248
23	INSERVICE TRAINING & EDUCATION			
	EDUCATION & SEMINARS		1,354	
				1,354
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	3,113	
				3,113
25	ADMIN. STAFF TRANSPORTATION			
	TRANSPORTATION - STAFF		0	
				0
26	INSURANCE - PROP. LIAB & MALPRACTICE			
	GENERAL INSURANCE		213,948	
				213,948
27	**OTHER**			
	BAD DEBTS	VI 24	120,000	
				120,000

GRAND TOTAL COLUMN 3 OTHER **775,791**

PARK RIDGE CARE CENTER
SCHEDULES
12/31/2020

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

TOTAL FOOD PURCHASE	63,682
LESS SALES TAX	(121)
NET FOOD	63,561
TOTAL PATIENT CENSUS	14,007
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	42,021
ADD # EMPLOYEE MEALS/DAY	6
TIMES # DAYS	366
TOTAL EMPLOYEE MEALS	2,196
PATIENT MEALS	42,021
ADD EMPLOYEE MEALS	2,196
TOTAL MEALS/YEAR	44,217
NET FOOD	63,561
DIVIDE TOTAL MEALS/YEAR	44,217
COST PER MEAL	1
TIMES EMPLOYEE MEALS	2,196
EMPLOYEE MEAL RECLASSIFICATION	**3,162**

Facility Name & ID Number PARK RIDGE CARE CENTER #0039255 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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			10,979	10,979		10,979	56,122	67,101			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							50,173	50,173			32
33	Real Estate Taxes							183,963	183,963			33
34	Rent-Facility & Grounds			360,000	360,000		360,000	(385,000)	(25,000)			34
35	Rent-Equipment & Vehicles			9,978	9,978		9,978	4,555	14,533			35
36	Other (specify):*							6,552	6,552			36
37	**TOTAL Ownership**			380,957	380,957		380,957	(83,635)	297,322			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		25,768	170,804	196,572		196,572		196,572			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			99,637	99,637		99,637		99,637			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		25,768	270,441	296,209		296,209		296,209			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,615,850	304,752	1,427,189	3,347,791		3,347,791	(131,479)	3,216,312			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: 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 Reference	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	8,675	30		9
10	Interest and Other Investment Income	(5,249)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(121)	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		21		18
19	Entertainment		20		19
20	Contributions	(5,083)	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	(120,000)	27		24
25	Fund Raising, Advertising and Promotional	(2,000)	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		22		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (123,778)		$	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)	(7,701)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (7,701)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (131,479)		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: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PARK RIDGE CARE CENTER # 0039255 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	(121)	0	0	0	0	0	0	0	0	0	0	(121)	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	507	0	0	0	0	0	0	0	0	507	5
6	Maintenance	0	1,201	3,150	0	0	0	0	0	0	0	0	4,351	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(121)	1,201	3,657	0	0	0	0	0	0	0	0	4,737	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	5,492	0	0	0	0	0	0	0	0	5,492	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	5,492	0	0	0	0	0	0	0	0	5,492	16
	C. General Administration													
17	Administrative	0	0	(15,000)	21,073	0	0	0	0	0	0	0	6,073	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,000	1,494	0	0	0	0	0	0	0	0	12,494	19
20	Fees, Subscriptions & Promotions	(7,083)	0	911	0	0	0	0	0	0	0	0	(6,172)	20
21	Clerical & General Office Expenses	0	0	3,895	9,054	0	0	0	0	0	0	0	12,949	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	119	0	0	0	0	0	0	0	0	119	24
25	Other Admin. Staff Transportation	0	0	1,185	0	0	0	0	0	0	0	0	1,185	25
26	Insurance-Prop.Liab.Malpractice	0	5,621	1,480	0	0	0	0	0	0	0	0	7,101	26
27	Other (specify):*	(120,000)	0	28,178	0	0	0	0	0	0	0	0	(91,822)	27
28	**TOTAL General Administration**	(127,083)	16,621	22,262	30,127	0	0	0	0	0	0	0	(58,073)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(127,204)	17,822	31,411	30,127	0	0	0	0	0	0	0	(47,844)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PARK RIDGE CARE CENTER **#** 0039255 **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	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	8,675	46,909	538	0	0	0	0	0	0	0	0	56,122	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,249)	54,425	997	0	0	0	0	0	0	0	0	50,173	32
33	Real Estate Taxes	0	182,089	1,874	0	0	0	0	0	0	0	0	183,963	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	4,555	0	0	0	0	0	0	0	0	4,555	35
36	Other (specify):*	0	6,552	0	0	0	0	0	0	0	0	0	6,552	36
37	**TOTAL Ownership**	3,426	(95,025)	7,964	0	0	0	0	0	0	0	0	(83,635)	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)**	(123,778)	(77,203)	39,375	30,127	0	0	0	0	0	0	0	(131,479)	45

Facility Name & ID Number PARK RIDGE CARE CENTER # 0039255 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 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	RENT	$ 385,000	665 BUSSEE HIGHWAY LP	100.00%	$	$ (385,000)	1
2	V								2
3	V	32	INTEREST				52,780	52,780	3
4	V	32	AMORTIZATION				1,645	1,645	4
5	V	30	DEPRECIATION				46,909	46,909	5
6	V	36	MIP INSURANCE				6,552	6,552	6
7	V	33	REAL ESTATE TAX				182,089	182,089	7
8	V	26	INSURANCE				5,621	5,621	8
9	V	19	PROFESSIONAL FEES				11,000	11,000	9
10	V	6	MAINTENANCE				1,201	1,201	10
11	V								11
12	V								12
13	V								13
14	Total			$ 385,000			$ 307,797	$ * (77,203)	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: 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	17	MANAGEMENT FEES	$ 15,000	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$	$ (15,000)	15
16	V	21	BOOKKEEPING SERVICES	45,000				(45,000)	16
17	V								17
18	V								18
19	V								19
20	V	5	UTILITIES				507	507	20
21	V	6	REPAIR & MAINT.-OTHER EXPENSE				3,150	3,150	21
22	V	10	NURSE CONSULTANT				5,492	5,492	22
23	V	19	PROFESSIONAL FEES				1,494	1,494	23
24	V	20	DUES AND SUBSCRIPTION				911	911	24
25	V	21	CLERICAL & GENERAL - SALARIES				37,449	37,449	25
26	V	21	CLERICAL & GENERAL-OTHER EXPENSE				11,446	11,446	26
27	V	24	SEMINARS AND TRAVEL				119	119	27
28	V	25	AUTO EXPENSE				1,185	1,185	28
29	V	26	INSURANCE				1,480	1,480	29
30	V	27	EMP. BEN. - GEN, ADMIN.				28,178	28,178	30
31	V	30	DEPRECIATION				538	538	31
32	V	32	INTEREST				997	997	32
33	V	33	REAL ESTATE TAXES				1,874	1,874	33
34	V	35	AUTO RENTAL				4,432	4,432	34
35	V	35	EQUIPMENT RENTAL				123	123	35
36	V								36
37	V								37
38	V								38
39	Total			$ 60,000			$ 99,375	$ * 39,375	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: 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	6	MAINT COMP - D NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$	$	15
16	V	17	ADMIN COMP - M MAUER				10,875	10,875	16
17	V	17	ADMIN COMP - M AARON						17
18	V	17	ADMIN COMP - F AARON						18
19	V	17	ADMIN COMP - D AARON				2,154	2,154	19
20	V	17	ADMIN COMP - S GOLDSTEIN						20
21	V	17	ADMIN COMP - R AARON						21
22	V	17	ADMIN COMP - S HARAMARAS						22
23	V	17	ADMIN COMP - D KUFTA						23
24	V	17	ADMIN COMP - HOWARD ALTER						24
25	V	17	ADMIN COMP - NON OWNER - V DAVIS						25
26	V	17	ADMIN COMP - CONTROLLER-NON OWNER				8,044	8,044	26
27	V	21	CLERICAL COMP - S AARON				6,711	6,711	27
28	V	21	CLERICAL COMP - E MARYLES				2,343	2,343	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 30,127	$ * 30,127	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: 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	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			Waterfront Terrace Inc	Chicago				4
5			Willow Crest Nursing Pavilion Ltd	Sandwich				5
6			Woodbridge Nursing Pavilion Ltd	Chicago				6
7								7
8								8
9			Woodbridge Supportive Living Residence of Ga	Galesberg				9
10			Woodbridge Supportive Living Residence of Ga	Geneseo				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: 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	
	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	1.74	4.35	SALARY	$ 10,875	17-07	1
2					ATTACHED						2
3	DANIEL AARON	RELATIVE	ADMINISTRATIVE			0.5	0.91	SALARY	2,154	17-07	3
4											4
5	SHARON AARON	RELATIVE	CLERICAL			2.8	7.00	SALARY	6,711	21-07	5
6											6
7	ESTHER MARYLES	RELATIVE	CLERICAL			1.3	3.25	SALARY	2,343	21-07	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 22,083		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: 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 3359 W MAIN STREET
Street Address SKOKIE, IL 60076
City / State / Zip Code 847) 679-8219
Phone Number (847) 679-7377
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	5	UTILITIES	PATIENT DAYS	296,074	9	$ 10,707	$	14,007	$ 507	1
2	6	REPAIR & MAINT.-OTHER EXPEI	PATIENT DAYS	296,074	9	66,584		14,007	3,150	2
3	10	NURSE CONSULTANT	PATIENT DAYS	296,074	9	116,092		14,007	5,492	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	296,074	9	31,579		14,007	1,494	4
5	20	DUES AND SUBSCRIPTION	PATIENT DAYS	296,074	9	19,254		14,007	911	5
6	21	CLERICAL & GENERAL - SALARI	PATIENT DAYS	296,074	9	791,573	791,573	14,007	37,449	6
7	21	CLERICAL & GENERAL-OTHER I	PATIENT DAYS	296,074	9	241,939		14,007	11,446	7
8	24	SEMINARS AND TRAVEL	PATIENT DAYS	296,074	9	2,520		14,007	119	8
9	25	AUTO EXPENSE	PATIENT DAYS	296,074	9	25,044		14,007	1,185	9
10	26	INSURANCE	PATIENT DAYS	296,074	9	31,289		14,007	1,480	10
11	27	EMP. BEN. - GEN. ADMIN.	PATIENT DAYS	296,074	9	595,611		14,007	28,178	11
12	30	DEPRECIATION	PATIENT DAYS	296,074	9	11,374		14,007	538	12
13	32	INTEREST	PATIENT DAYS	296,074	9	21,081		14,007	997	13
14	33	REAL ESTATE TAXES	PATIENT DAYS	296,074	9	39,621		14,007	1,874	14
15	35	AUTO RENTAL	PATIENT DAYS	296,074	9	93,680		14,007	4,432	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	296,074	9	2,605		14,007	123	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,100,553	$ 791,573		$ 99,375	25

Facility Name & ID Number PARK RIDGE CARE CENTER # 0039255 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: 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	5	$ 58,624	$ 58,624		$	1
2	17	ADMIN COMP - M MAUER	WGHTD AVG HOURS	40	9	250,000	250,000	2	10,875	2
3	17	ADMIN COMP - M AARON	WGHTD AVG HOURS	40	5	250,000	250,000			3
4	17	ADMIN COMP - F AARON	WGHTD AVG HOURS	45	3	127,500	127,500			4
5	17	ADMIN COMP - D AARON	WGHTD AVG HOURS	5	9	21,541	21,541	1	2,154	5
6	17	ADMIN COMP - S GOLDSTEIN	WGHTD AVG HOURS	40	2	230,000	230,000			6
7	17	ADMIN COMP - R AARON	WGHTD AVG HOURS	6	3	21,541	21,541			7
8	17	ADMIN COMP - S HARAMARAS	WGHTD AVG HOURS	30	1	69,011	69,011			8
9	17	ADMIN COMP - D KUFTA	WGHTD AVG HOURS	40	5	168,022	168,022			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	5	132,015	132,015			11
12	17	ADMIN COMP - CONTROLLER-N	WGHTD AVG HOURS	40	9	114,916	114,916	3	8,044	12
13	21	CLERICAL COMP - S AARON	WGHTD AVG HOURS	40	9	95,871	95,871	3	6,711	13
14	21	CLERICAL COMP - E MARYLES	WGHTD AVG HOURS	40	9	72,080	72,080	1	2,343	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,623,121	$ 1,623,121		$ 30,127	25

Facility Name & ID Number PARK RIDGE CARE CENTER # 0039255 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	GREYSTONE SERVICING CO		X	MORTGAGE		9/25/15	$ 1,307,000	$ 1,155,355	1/1/42	4.5000	$ 52,780	1
2												2
3	LOAN COSTS	X		LOAN COSTS	W/O OVER LOAN		44,965	36,191			1,645	3
4												4
5												5
	Working Capital											
6												6
7												7
8	RELATED PARTY ALLOCATION										997	8
9	TOTAL Facility Related						$ 1,351,965	$ 1,191,546			$ 55,422	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,351,965	$ 1,191,546			$ 55,422	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 6,552 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: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	183,963	2
3. Under or (over) accrual (line 2 minus line 1).	$	183,963	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$		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.	$	183,963	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2015	192,074	8
2016	172,663	9
2017	195,574	10
2018	196,410	11
2019	183,963	12

FOR BHF USE ONLY

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 PARK RIDGE CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0039255

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.	09-27-213-053-0000	NURSING HOME	$ 182,088.51	$ 182,088.51
2.			$	$
3.			$	$
4.			$	$
5.	10-23-404-059-0000	DYNAMIC HEALTHCARE	$ 36,915.77	$ 1,874.00
6.		ALLOCATION	$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 219,004.28	$ 183,962.51

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.

Facility Name & ID Number PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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: 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	46		1986	1986	$ 1,323,000	$	39	$ 33,923	$ 33,923	$ 917,335	4
5											5
6											6
7											7
8	RELATED PARTY ALLOCATION				21,248			607	607		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	21,547	11
12	Various			1998	18,893		20	719	719	18,893	12
13	Various			1999	7,527		20	376	376	7,527	13
14	Various			2000	68,323		20	3,376	3,376	69,268	14
15	Various			2001	3,525		20	81	81	3,463	15
16	Various			2002	5,638		20	185	185	5,361	16
17	Various			2003	24,130		20	350	350	23,201	17
18	Various			2004	3,490		20	175	175	2,872	18
19	Various			2005	1,858		20	93	93	1,435	19
20	Various			2006	6,500		20	325	325	4,633	20
21	Various			2008	11,545		20	573	573	10,281	21
22	Various			2010	6,813		20	273	273	2,876	22
23	Various			2011	11,965		20	307	307	2,847	23
24	Various			2012	25,060		20	643	643	5,607	24
25	Various			2013	5,920		20	152	152	1,196	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: 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			$	$		$	$	$	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	BOOK DEPRECIATION			58,426			(58,426)		62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,608,983	$ 58,426		$ 42,698	$ (15,728)	$ 1,140,343	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: 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	
1	Totals from Page 12A, Carried Forward		$ 1,608,983	$ 58,426		$ 42,698	$ (15,728)	$ 1,140,343	1
2	Security cameras	2014	2,580		20	369	369	2,428	2
3	Remodeling supplies - window installation	2014	2,760		20	552	552	3,496	3
4	Tuckpointing/painting	2014	5,000		20	100	100	3,633	4
5	Install fire prevention device	2015	4,300		20	123	123	707	5
6	Repair leaking pipes above corridor ceiling	2016	2,988		20	149	149	721	6
7	Blinds for resident rooms	2017	3,300		20	31	31	124	7
8	New piping and sod exterior	2017	4,392		20	10	10	40	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)		$ 1,634,303	$ 58,426		$ 44,032	$ (14,394)	$ 1,151,492	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: 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	
1	Totals from Page 12B, Carried Forward		$ 1,634,303	$ 58,426		$ 44,032	$ (14,394)	$ 1,151,492	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	10,383	9
10	Nursing station	2008	5,000		20	250	250	3,667	10
11	Nursing station	2008	4,700		20	235	235	3,447	11
12	Econocare call light system	2008	12,011		20	601	601	9,213	12
13	Jacks & Son asphalt parking lot	2008	16,033		20	802	802	11,494	13
14	Flooring	2008	14,000		20	779	779	10,906	14
15	Drop ceiling & lighting	2009	19,000		20	950	950	12,983	15
16	Roof rubber installation	2009	3,000		20	150	150	1,975	16
17	Lobby - Wallpaper, vinyl time, millwork, cove base	2010	4,185		20	209	209	2,299	17
18	Conference room - wallpaper, vinyl tile, millwork, cove base	2010	3,909		20	195	195	2,145	18
19	Corridor - wallpaper, vinyl tile, millwork, cove base	2010	19,821		20	991	991	10,901	19
20	Various areas: wallcovering, vinyl floor, paint (doors, frames)	2010	48,069		20	2,403	2,403	26,434	20
21	Door	2011	11,077		20	554	554	5,540	21
22	Double entry kithcen door	2011	3,450		20	173	173	1,730	22
23	Built in cabinet and countertop	2011	6,775		20	339	339	3,390	23
24	Remodeling of 2 bathrooms	2013	19,965		20	998	998	6,986	24
25	Roof replacement	2013	14,300		20	715	715	5,005	25
26	Remove/replace floor tile with ceramic tile in kitchen	2013	5,875		20	294	294	1,764	26
27	Kitchen hood	2015	14,500		20	725	725	4,350	27
28	Remove/replace basement walls	2015	11,875		20	594	594	3,564	28
29	Kitchen floor tile, replace pipes, countertop	2015	32,681		20	1,634	1,634	9,804	29
30	Patio and sidewalk concrete work	2015	5,500		20	275	275	1,375	30
31	Roof repairs	2016	22,900		20	1,145	1,145	5,725	31
32	Window replacement	2016	14,869		20	929	929	4,645	32
33	Gutters and downspouts	2016	3,495		20	175	175	875	33
34	TOTAL (lines 1 thru 33)		$ 1,965,293	$ 58,426		$ 60,847	$ 2,421	$ 1,312,092	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: 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	
1	Totals from Page 12C, Carried Forward		$ 1,965,293	$ 58,426		$ 60,847	$ 2,421	$ 1,312,092	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	8,564	3
4	Replace metal door in basement, install electrical panel door locks	2017	2,768		20	138	138	552	4
5	Window repair in basement - thermal treatement	2017	4,217		20	211	211	844	5
6	Concrete Ramp to kitchen, replace Apron and sidewalk	2019	5,475		10	548	548	1,096	6
7	Add electrical line for dishwasher, Replace breaker	2019	2,196		10	146	146	292	7
8	Building Tuckpointing	2019	3,000		10	200	200	400	8
9	Sidewalk Replacement	2019	1,710		10	100	100	200	9
10	Lighting-Energy Efficiency Project	2020	8,303		20	415	415	415	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)		$ 2,035,762	$ 58,426		$ 64,745	$ 6,319	$ 1,324,455	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: 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	$ 41,717	$	$ 2,202	$ 2,202	5-10	$ 34,952	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	163,979					163,979	73
74	RELATED PARTY			154	154			74
75	TOTALS	$ 205,696	$	$ 2,356	$ 2,356		$ 198,931	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)	$ 2,290,458	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 58,426	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 67,101	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 8,675	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,523,386	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: 1/1/2020 Ending: 12/31/2020

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 ☒ NO

16. Rental Amount for movable equipment: $ 1,431 Description: LEAF - COPIERS
(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	2017 CHEVROLET	$ 529.00	$ 8,547	17
18		TRAVERSE			18
19					19
20					20
21	TOTAL		$ 529.00	$ 8,547	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: 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	$		$ 79,644	$		$ 79,644	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			997			997	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			90,163			90,163	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				21,406		21,406	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	MED.SUPPLIES/LAB/RADIOLOGY Other (specify):	39-2					4,362		0 4,362	13
14	TOTAL			$		$ 170,804	$ 25,768		$ 196,572	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: 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	$ 1,467,438	$ 1,539,628	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 475,064)	745,622	745,622	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	66,578	73,265	6
7	Other Prepaid Expenses	9,761	10,789	7
8	Accounts Receivable (owners or related parties)		50,000	8
9	Other(specify): ESCROWS		255,630	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,289,399	$ 2,674,934	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	698,470	15
16	Equipment, at Historical Cost	205,696	483,145	16
17	Accumulated Depreciation (book methods)	(476,694)	(1,835,342)	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			22
23	Other(specify): LOAN COSTS		36,191	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 134,473	$ 754,464	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,423,872	$ 3,429,398	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 384,955	$ 384,955	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	463,336	496,974	29
30	Accrued Salaries Payable	137,688	137,688	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,221	2,221	31
32	Accrued Real Estate Taxes(Sch.IX-B)		90,000	32
33	Accrued Interest Payable		4,333	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)**	$ 988,200	$ 1,116,171	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,121,717	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)**	$	$ 1,121,717	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 988,200	$ 2,237,888	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,435,672	$ 1,191,510	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,423,872	$ 3,429,398	48

*(See instructions.)

Facility Name & ID Number PARK RIDGE CARE CENTER # 0039255 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**	$ 990,865	1
2	Restatements (describe):		2
3	PRIOR	(5,238)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 985,627	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	510,045	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)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 450,045	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)**	$ 1,435,672	24 *

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

Facility Name & ID Number PARK RIDGE CARE CENTER # 0039255 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	$ 3,517,981	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,517,981	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	67,337	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 67,337	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***	5,249	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,249	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	STIMULUS PAYMENT	428,380	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 428,380	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,018,947	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	568,281	31
32	Health Care	1,201,173	32
33	General Administration	901,171	33
	B. Capital Expense		
34	Ownership	380,957	34
	C. Ancillary Expense		
35	Special Cost Centers	196,572	35
36	Provider Participation Fee	99,637	36
	D. Other Expenses (specify):		
37	Prior Year Adjustment	161,111	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,508,902	40
41	**Income before Income Taxes (line 30 minus line 40)****	510,045	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 510,045	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,100,423	44
45	Private Pay - Net Inpatient Revenue	175,304	45
46	Medicare - Net Inpatient Revenue	1,242,254	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,517,981	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES 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: 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 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	5,641	5,728	$ 254,854	$ 44.49	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,516	4,960	178,130	35.91	3
4	Licensed Practical Nurses	2,408	2,481	68,146	27.47	4
5	CNAs & Orderlies	28,906	31,310	483,789	15.45	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,054	2,167	51,395	23.72	9
10	Activity Assistants	2,574	2,661	34,457	12.95	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,550	2,647	68,230	25.78	13
14	Head Cook	3,146	3,381	54,282	16.06	14
15	Cook Helpers/Assistants	4,884	4,994	70,613	14.14	15
16	Dishwashers					16
17	Maintenance Workers	2,006	2,127	54,107	25.44	17
18	Housekeepers	5,721	6,448	82,085	12.73	18
19	Laundry	2,690	2,774	37,251	13.43	19
20	Administrator	2,107	2,243	152,275	67.89	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,340	1,412	26,236	18.58	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)	70,543	75,333	$ 1,615,850 *	$ 21.45	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 0	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	0	10-3	38
39	Pharmacist Consultant	H	2,912	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	627	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)		$ 9,539		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	206	3,410	10-3	52
53	TOTAL (lines 50 - 52)	206	$ 3,410		53

Facility Name & ID Number PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ROB WEISZ	ADMINISTRATOR	0	$ 152,275
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 152,275

B. Administrative - Other

Description	Amount
DYNAMIC HEALTHCARE MANAGEMENT FEES	$ 15,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 15,000

C. Professional Services

Vendor/Payee	Type	Amount
E-SOLUTIONS	DATA PROCESSING	$ 1,624
HDSI	DATA PROCESSING	3,167
NATIONAL DATACARE CORPOR	DATA PROCESSING	2,520
POINTCLICKCARE TECHNOLOG	DATA PROCESSING	18,545
KBKB LTD	ACCOUNTING FEES	8,550
PERSONNEL PLANNERS	UNEMPLOYMENT TAX CONS	660
TERRILL CONSULTING SERVICE	MDS CONSULTING	15,194
STOUT RISUS ROSS INC	VALUATION ADVISORY	5,000
RICHARD PEELO & ASSOC	MEDICARE CONSULTANT	3,500
SEE ATTACHED	LEGAL	3,021
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 61,781

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 34,263
Unemployment Compensation Insurance	5,862
FICA Taxes	114,231
Employee Health Insurance	26,416
Employee Meals	3,162
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	20,476
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)	$ 204,410

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	$ 1,990
Advertising: Employee Recruitment	1,586
Health Care Worker Background Check	0
(Indicate # of checks performed)	
Patient Background Checks 17	170
TRUST/FRANCHISE/CONTRIB/ETC	5,083
MARKETING/ADV/PROMO	2,000
LICENSES/DUES/SUBSCRIPTIONS	13,400
MGMT CO ALLOC	911
TRUST/FRANCHISE/CONTRIB/ETC	(5,083)
Less: Public Relations Expense	(0)
Non-allowable advertising	(2,000)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,057

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	3,113
MGMT CO ALLOC	119
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,232

* Attach copy of IMRF notifications

**See instructions.

PARK RIDGE CARE CENTER
SCHEDULE - LEGAL
12/31/2020

DATE	VENDOR	DESCRIPTION	AMOUNT
11/15/2019	Baker Donelson	Privacy and Security Matters	1,726
12/16/2019	Baker Donelson	Privacy and Security Matters	125
1/1/2020	Much Shelist	General Counseling	1,170
		TOTAL	**3,021**

Facility Name & ID Number PARK RIDGE CARE CENTER # 0039255 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ICLTC-$ 1,863**

(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. $ **22,718** 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 **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. $ **99,637**
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. $ **3,162** 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.