



Facility Name & ID Number Norridge Gardens

# 0052431 Report Period Beginning: 01/01/14 Ending: 12/31/14

III. STATISTICAL DATA

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

	1	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	292	Skilled (SNF)	292	106,580	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	292	TOTALS	292	106,580	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	48,843	16,254	29,683	94,780	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,843	16,254	29,683	94,780	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.93%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold 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? None

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 8/1/2013

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 8/1/2013 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 292 and days of care provided 22,495

Medicare Intermediary CGS Administrators, LLC

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	703,296	58,295	19,761	781,352		781,352		781,352	1	
2	Food Purchase		712,870		712,870		712,870	(1,223)	711,647	2	
3	Housekeeping	15,769	21,033	401,673	438,475		438,475		438,475	3	
4	Laundry	6,846	12,652	262,072	281,570		281,570		281,570	4	
5	Heat and Other Utilities			190,984	190,984		190,984	(1,019)	189,965	5	
6	Maintenance	112,848		202,327	315,175		315,175	108,795	423,970	6	
7	Other (specify):*							3,267	3,267	7	
8	<b>TOTAL General Services</b>	838,759	804,850	1,076,817	2,720,426		2,720,426	109,820	2,830,246	8	
	<b>B. Health Care and Programs</b>										
9	Medical Director			42,000	42,000		42,000		42,000	9	
10	Nursing and Medical Records	5,621,033	559,422	25,236	6,205,691		6,205,691	85,052	6,290,743	10	
10a	Therapy	439,052	5,327	22,000	466,379		466,379		466,379	10a	
11	Activities	327,454	19,921	2,864	350,239		350,239		350,239	11	
12	Social Services	240,693		5,920	246,613		246,613		246,613	12	
13	CNA Training									13	
14	Program Transportation			4,527	4,527		4,527		4,527	14	
15	Other (specify):*							14,905	14,905	15	
16	<b>TOTAL Health Care and Programs</b>	6,628,232	584,670	102,547	7,315,449		7,315,449	99,957	7,415,406	16	
	<b>C. General Administration</b>										
17	Administrative	204,668		1,345,287	1,549,955		1,549,955	(1,162,772)	387,183	17	
18	Directors Fees									18	
19	Professional Services			232,305	232,305	(10,476)	221,829	25,913	247,742	19	
20	Dues, Fees, Subscriptions & Promotions			66,423	66,423		66,423	(37,346)	29,077	20	
21	Clerical & General Office Expenses	354,135	109,598	415,167	878,900		878,900	(181,330)	697,570	21	
22	Employee Benefits & Payroll Taxes			1,608,096	1,608,096		1,608,096		1,608,096	22	
23	Inservice Training & Education									23	
24	Travel and Seminar			9,467	9,467		9,467	1,026	10,493	24	
25	Other Admin. Staff Transportation			14,659	14,659		14,659		14,659	25	
26	Insurance-Prop.Liab.Malpractice			187,375	187,375		187,375	6,598	193,973	26	
27	Other (specify):*							51,173	51,173	27	
28	<b>TOTAL General Administration</b>	558,803	109,598	3,878,779	4,547,180	(10,476)	4,536,704	(1,296,738)	3,239,966	28	
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	8,025,794	1,499,118	5,058,143	14,583,055	(10,476)	14,572,579	(1,086,961)	13,485,618	29	

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name &amp; ID Number

Norridge Gardens

#0052431

Report Period Beginning:

01/01/14

Ending:

12/31/14

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation							45,372	45,372			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,800	33,800		33,800	(1,008)	32,792			32
33	Real Estate Taxes			886,600	886,600	10,476	897,076		897,076			33
34	Rent-Facility & Grounds			3,488,193	3,488,193		3,488,193	(51,749)	3,436,444			34
35	Rent-Equipment & Vehicles			1,043	1,043		1,043		1,043			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			4,409,636	4,409,636	10,476	4,420,112	(7,385)	4,412,727			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		961,178	2,371,583	3,332,761		3,332,761		3,332,761			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			600,009	600,009		600,009		600,009			42
43	Other (specify):*	213,915	4,765	39,326	258,006		258,006	(258,006)	(0)			43
44	<b>TOTAL Special Cost Centers</b>	213,915	965,943	3,010,918	4,190,776		4,190,776	(258,006)	3,932,770			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	8,239,709	2,465,061	12,478,697	23,183,467		23,183,467	(1,352,352)	21,831,115			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 Norridge Gardens

# 0052431

Report Period Beginning: 01/01/14

Ending: 12/31/14

**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.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(3,985)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	29,595	30		9
10	Interest and Other Investment Income	(1,008)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,223)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(7,734)	21		18
19	Entertainment				19
20	Contributions	(35,094)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(300,000)	21		24
25	Fund Raising, Advertising and Promotional	(2,275)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(305,086)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (626,810)</b>		<b>\$</b>	<b>30</b>

**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	2	
		<b>Amount</b>	<b>Reference</b>	
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)	(725,542)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (725,542)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (1,352,352)</b>		<b>37</b>

\*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	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

<b>BHF USE ONLY</b>						
48		49		50		51
						52

Norridge Gardens

ID# 0052431

Report Period Beginning: 01/01/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Marketing Salaries	\$ (213,915)	43	1
2	Marketing Expenses	(15,329)	43	2
3	Late Fees	(4,508)	21	3
4	Bank Charges	(42,972)	21	4
5	2013 Additional R&M	20,417	06	5
6	2014 Additional R&M	82,381	06	6
7	Fundraising Consultant	(28,762)	43	7
8	Capitalized R&M	(15,699)	06	8
9	Rental Income	(89,583)	34	9
10	Estate Planning	(4,616)	19	10
11	Web Design	7,500	21	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	<b>Total</b>		(305,086)	49

Norridge Gardens

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Report Period Beginning: 01/01/14

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32

82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Norridge Gardens# 0052431

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(1,223)											(1,223)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(3,985)		2,966									(1,019)	5
6	Maintenance	87,099		21,696									108,795	6
7	Other (specify):*			3,267									3,267	7
8	<b>TOTAL General Services</b>	<b>81,891</b>		<b>27,929</b>									<b>109,820</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records			94,027	(8,975)								85,052	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			14,905									14,905	15
16	<b>TOTAL Health Care and Programs</b>			<b>108,932</b>	<b>(8,975)</b>								<b>99,957</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(1,162,772)									(1,162,772)	17
18	Directors Fees													18
19	Professional Services	(4,616)		30,529									25,913	19
20	Fees, Subscriptions & Promotions	(37,369)		23									(37,346)	20
21	Clerical & General Office Expenses	(347,714)		166,384									(181,330)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,026									1,026	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			6,598									6,598	26
27	Other (specify):*			51,173									51,173	27
28	<b>TOTAL General Administration</b>	<b>(389,699)</b>		<b>(907,039)</b>									<b>(1,296,738)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(307,808)</b>		<b>(770,178)</b>	<b>(8,975)</b>								<b>(1,086,961)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Norridge Gardens

# 0052431

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	29,595		15,777									45,372	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,008)											(1,008)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds	(89,583)		37,834									(51,749)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>(60,996)</b>		<b>53,611</b>									<b>(7,385)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(258,006)											(258,006)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(258,006)</b>											<b>(258,006)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(626,810)</b>		<b>(716,567)</b>	<b>(8,975)</b>								<b>(1,352,352)</b>	<b>45</b>

**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 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	<b>Total</b>		\$			\$	\$ *	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 UTILITIES	\$	PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	\$ 2,966	\$ 2,966 15
16	V	6 REPAIRS AND MAINTENANCE		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	21,696	21,696 16
17	V	7 EMPLOYEE BEN. GEN SERVICES.		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	3,267	3,267 17
18	V	10 NURSING SALARY		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	94,027	94,027 18
19	V	15 EMPLOYEE BEN. HEALTH CARE.		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	14,905	14,905 19
20	V	17 NON-OWNER ADMIN. COMP.		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	94,890	94,890 20
21	V	17 SALARY - DAVID CHEPLOWITZ		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	44,254	44,254 21
22	V	17 SALARY - BARAK BAVER		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	43,371	43,371 22
23	V	19 PROFESSIONAL FEES		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	30,529	30,529 23
24	V	20 LICENSES		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	23	23 24
25	V	21 OFFICE EXPENSE		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	153,273	153,273 25
26	V	24 SEMINARS		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	1,026	1,026 26
27	V	26 GENERAL INSURANCE		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	6,598	6,598 27
28	V	27 EMPLOYEE BEN. GEN ADMIN.		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	49,024	49,024 28
29	V	30 DEPRECIATION		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	15,777	15,777 29
30	V	34 RENT		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	37,834	37,834 30
31	V						
32	V						
33	V	21 CLERICAL SALARY		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	13,111	13,111 33
34	V	27 EMPLOYEE BEN. GEN ADMIN.		PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%	2,149	2,149 34
35	V						
36	V	17 MANAGEMENT FEES	1,345,287	PREMIER HEALTHCARE MANAGEMENT, LLC	100.00%		(1,345,287) 36
37	V						
38	V						
39	Total		\$ 1,345,287			\$ 628,720	\$ * (716,567) 39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10 MEDICAL SUPPLIES	\$ 16,833	PREMIER HEALTHCARE SUPPLIES, LLC	100.00%	\$ 7,858	\$ (8,975)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 16,833			\$ 7,858	\$ * (8,975)

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

Facility Name & ID Number

Norridge Gardens

# 0052431

Report Period Beginning:

01/01/14

Ending:

12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	BARAK BAVER	25.00%	GILMAN HEALTHCARE CENTER,LLC	GILMAN	PREMIER HEALTHCARE MANA	CHICAGO	MANAGEMENT CO.	1
2	DAVID CHEPLOWITZ	25.00%	COURTYARD HEALTHCARE	BERWYN	PREMIER HEALTHCARE SUPPI	CHICAGO	MEDICAL SUPPLY	2
3	EREZ BAVER	5.00%	WINFIELD WOODS HEALTHCARE CENTER, LLC	WINFIELD				3
4	NETZACH INVESTMENTS	45.00%	PERSHING GARDENS HEALTHCARE CENTER	STICKNEY				4
5			GARDENVIEW MANOR	DANVILLE				5
6			CHAMPAIGN URBANA NURSING AND REHAB	SAVOY				6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number

Norridge Gardens

# 0052431

Report Period Beginning:

01/01/14

Ending:

12/31/14

VII. RELATED PARTIES

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

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

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 01/01/14 Ending: 12/31/14

## 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	David Cheplowitz	Shareholder	Administrative	25.00%	See Attached	12	30.00%	Mgmt Fee	\$ 44,254	17-7	1
2	Barak Baver	Shareholder	Administrative	25.00%	See Attached	12	30.00%	Mgmt Fee	43,371	17-7	2
3	Sara Baver	Relative	Clerical	0	See Attached	13	32.50%	Alloc Salary	13,111	21-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 100,736		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Norridge Gardens

# 0052431 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Norridge Gardens

# 0052431

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization PREMIER HEALTHCARE MANAGEMENT, L  
 Street Address 8170 N. MCCORMICK BLVD. SUITE 137  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number ( 847) 674-2800  
 Fax Number ( 847) 674-4133

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	UTILITIES	PATIENT DAYS	314,061	7	\$ 9,829	\$ 94,780	\$ 2,966	1	
2	6	REPAIRS AND MAINTENANC	PATIENT DAYS	314,061	7	71,891	68,695	94,780	21,696	2
3	7	EMPLOYEE BEN. GEN SERVI	PATIENT DAYS	314,061	7	10,826	94,780	3,267	3	
4	10	NURSING SALARY	PATIENT DAYS	314,061	7	311,565	311,565	94,780	94,027	4
5	15	EMPLOYEE BEN. HEALTH C	PATIENT DAYS	314,061	7	49,390	94,780	14,905	5	
6	17	NON-OWNER ADMIN. COM	PATIENT DAYS	314,061	7	314,424	314,424	94,780	94,890	6
7	17	SALARY - DAVID CHEPLOW	PATIENT DAYS	314,061	7	146,638	146,638	94,780	44,254	7
8	17	SALARY - BARAK BAVER	PATIENT DAYS	314,061	7	143,713	143,713	94,780	43,371	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	314,061	7	101,159	94,780	30,529	9	
10	20	LICENSES	PATIENT DAYS	314,061	7	75	94,780	23	10	
11	21	OFFICE EXPENSE	PATIENT DAYS	314,061	7	507,883	457,467	94,780	153,273	11
12	24	SEMINARS	PATIENT DAYS	314,061	7	3,398	94,780	1,026	12	
13	26	GENERAL INSURANCE	PATIENT DAYS	314,061	7	21,863	94,780	6,598	13	
14	27	EMPLOYEE BEN. GEN ADMIN	PATIENT DAYS	314,061	7	162,446	94,780	49,024	14	
15	30	DEPRECIATION	PATIENT DAYS	314,061	7	52,279	94,780	15,777	15	
16	34	RENT	PATIENT DAYS	314,061	7	125,366	94,780	37,834	16	
17									17	
18					-				18	
19	21	CLERICAL SALARY	PATIENT DAYS	40	6	40,341	40,341	13	13,111	19
20	27	EMPLOYEE BEN. GEN ADMIN	PATIENT DAYS	40	6	6,613	13	2,149	20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 2,079,699	\$ 1,482,843	\$ 628,720	25	

Facility Name & ID Number Norridge Gardens

# 0052431 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization PREMIER HEALTHCARE SUPPLIES, LLC  
 Street Address 8170 N. MCCORMICK BLVD. SUITE 137  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number ( 847) 674-2800  
 Fax Number ( 847) 674-4133

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	MEDICAL SUPPLIES	REVENUE	96,891	7	\$ 45,232	\$ 8,910	\$ 7,858	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 45,232	\$	\$ 7,858	25

Facility Name & ID Number Norridge Gardens

# 0052431 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Norridge Gardens

# 0052431 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Norridge Gardens

# 0052431 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Norridge Gardens

# 0052431 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Norridge Gardens

# 0052431 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Norridge Gardens

# 0052431 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Norridge Gardens

# 0052431 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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



Facility Name & ID Number Norridge Gardens

# 0052431

Report Period Beginning:

01/01/14

Ending:

12/31/14

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	Name of Lender	2		3	4	5	6		8	9	10						
		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			
	<b>A. Directly Facility Related</b>																
	<b>Long-Term</b>																
1							\$	\$			\$						
2																	
3																	
4																	
5																	
6																	
7	<b>TOTAL Long-Term</b>																
	<b>Working Capital</b>																
8							\$	\$			\$						
9																	
10																	
11																	
12																	
13																	
14	<b>TOTAL Working Capital</b>																
	<b>B. Non-Facility Related*</b>																
15							\$	\$			\$						
16																	
17																	
18																	
19																	
20	<b>TOTAL Non-Facility Related</b>																

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

SEE ACCOUNTANTS' COMPILATION REPORT

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



## 2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Norridge Gardens COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0052431

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>13-18-318-008-0000</u>	<u>Long Term Care Propety</u>	\$ <u>238,331.61</u>	\$ <u>238,331.61</u>
2. <u>13-18-318-006-0000</u>	<u>Long Term Care Propety</u>	\$ <u>219,802.27</u>	\$ <u>219,802.27</u>
3. <u>13-18-318-005-0000</u>	<u>Long Term Care Propety</u>	\$ <u>247,596.54</u>	\$ <u>247,596.54</u>
4. <u>13-18-318-007-0000</u>	<u>Long Term Care Propety</u>	\$ <u>221,660.65</u>	\$ <u>221,660.65</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>927,391.07</u></u>	\$ <u><u>927,391.07</u></u>

**B. Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

**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.**



4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ _____	\$ _____

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Norridge Gardens

# 0052431 Report Period Beginning:

01/01/14 Ending:

12/31/14

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 89,972 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 4

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (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?  (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).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number Norridge Gardens

# 0052431

Report Period Beginning:

01/01/14

Ending:

12/31/14

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
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

\*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 Norridge Gardens

# 0052431

Report Period Beginning:

01/01/14

Ending:

12/31/14

**XI. OWNERSHIP COSTS (continued)**

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	<u>Related Building Company (Pages 12F &amp; 12G)</u>								67
68	<u>Related Party Allocations (Pages 12H &amp; 12I)</u>			7,512	68	375	307	449	68
69	<u>Financial Statement Depreciation</u>								69
70	<b>TOTAL (lines 4 thru 69)</b>		\$	7,512	\$ 68	\$ 375	\$ 307	\$ 449	70

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

Facility Name & ID Number Norridge Gardens

# 0052431

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 7,512	\$ 68		\$ 375	\$ 307	\$ 449	1
2	Replace Elevator Door Operator	2013	11,472		20	287	287	717	2
3	Replace Pumping Unit	2013	13,952		20	349	349	872	3
4	Boiler Repair & Rtu	2013	5,992		20	599	599	1,298	4
5	Build Wood Planters	2013	12,750		20	319	319	850	5
6	Sprinkler Systems Heads & Valves In Parking Lot Foyer & South Dock	2013	3,388		20	85	85	226	6
7	Install Awning & Sign	2013	8,944		20	224	224	484	7
8	Fire Sprinkler Repair	2014	2,929		20	146	146	146	8
9	Re-Doing Wiring And Computer Systems (Singer)	2014	22,057		20	1,103	1,103	1,103	9
10	Repair Staircases On All 4 Floors	2014	6,600		20	330	330	330	10
11	Install Shunt Trip Breaker & Panelboard For Freight Elevator	2014	6,800		20	340	340	340	11
12	Hooking Up Emergency Power & Fire Service Wiring	2014	5,010		20	251	251	251	12
13	Fire Doors	2014	3,000		20	150	150	150	13
14	All Areas Carpet & Millwork Cove Base, Bthrm Tile	2014	31,551		20	1,578	1,578	1,578	14
15	Convert 2 Rms On 2Nd Fl To 2 Single Bdrms & Bathroom	2014	70,300		20	3,515	3,515	3,515	15
16	Fire Doors	2014	3,360		20	168	168	168	16
17	Water Heater Surface Ignitor	2014	3,957		20	396	396	396	17
18	Install New Elevator Care Doors	2014	2,669		20	133	133	133	18
19	Install New Elevator Care Doors	2014	2,669		20	133	133	133	19
20	Hot Water Pump Motor	2014	2,500		20	250	250	250	20
21	Install New Elevator Care Doors	2014	2,669		20	133	133	133	21
22	Fire Alarm System	2014	4,270		20	213	213	213	22
23	Sprinkler System Repair	2014	2,523		20	126	126	126	23
24	Fire Alarm Repair	2014	3,264		20	163	163	163	24
25	Replace Packing & Repair Leaking Valves	2014	2,974		20	149	149	149	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 243,110	\$ 68		\$ 11,515	\$ 11,447	\$ 14,174	34

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

Facility Name & ID Number Norridge Gardens

# 0052431

Report Period Beginning:

01/01/14

Ending:

12/31/14

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1		\$ 243,110	\$ 68		\$ 11,515	\$ 11,447	\$ 14,174		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 243,110	\$ 68		\$ 11,515	\$ 11,447	\$ 14,174		34

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

Facility Name & ID Number **Norridge Gardens**

# **0052431**

Report Period Beginning:

**01/01/14**

Ending:

**12/31/14**

**XI. OWNERSHIP COSTS (continued)**

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ <b>243,110</b>	\$ <b>68</b>		\$ <b>11,515</b>	\$ <b>11,447</b>	\$ <b>14,174</b>	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	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>243,110</b>	\$ <b>68</b>		\$ <b>11,515</b>	\$ <b>11,447</b>	\$ <b>14,174</b>	34

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

Facility Name & ID Number **Norridge Gardens**

# **0052431**

Report Period Beginning:

**01/01/14**

Ending:

**12/31/14**

**XI. OWNERSHIP COSTS (continued)**

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12D, Carried Forward</b>		\$ <b>243,110</b>	\$ <b>68</b>		\$ <b>11,515</b>	\$ <b>11,447</b>	\$ <b>14,174</b>	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	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>243,110</b>	\$ <b>68</b>		\$ <b>11,515</b>	\$ <b>11,447</b>	\$ <b>14,174</b>	34

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

Facility Name & ID Number **Norridge Gardens**

# **0052431**

Report Period Beginning:

**01/01/14**

Ending:

**12/31/14**

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12E, Carried Forward</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3									3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements</b>								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	<b>TOTAL (lines 1 thru 33)</b>		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number **Norridge Gardens**

# **0052431**

Report Period Beginning:

**01/01/14**

Ending:

**12/31/14**

**XI. OWNERSHIP COSTS (continued)**

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12F, Carried Forward</b>		\$	\$		\$	\$	\$	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	<b>TOTAL (lines 1 thru 33)</b>		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number **Norridge Gardens**

# **0052431**

Report Period Beginning:

**01/01/14**

Ending:

**12/31/14**

**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	<b>Totals from Page 12G, Carried Forward</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3									3
4									4
5									5
6									6
7									7
8	<b>Leasehold Information</b>								8
9	<b>Allocated from Premier Healthcare Management</b>	<b>2013</b>	<b>7,512</b>	<b>68</b>	<b>20</b>	<b>375</b>	<b>307</b>	<b>449</b>	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
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31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>7,512</b>	\$ <b>68</b>		\$ <b>375</b>	\$ <b>307</b>	\$ <b>449</b>	34

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

Facility Name & ID Number Norridge Gardens

# 0052431

Report Period Beginning:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12H, Carried Forward</b>								
2		\$ 7,512	\$ 68		\$ 375	\$ 307	\$ 449		1
3									2
4									3
5									4
6									5
7									6
8									7
9									8
10									9
11									10
12									11
13									12
14									13
15									14
16									15
17									16
18									17
19									18
20									19
21									20
22									21
23									22
24									23
25									24
26									25
27									26
28									27
29									28
30									29
31									30
32									31
33									32
34	<b>TOTAL (lines 1 thru 33)</b>	\$ 7,512	\$ 68		\$ 375	\$ 307	\$ 449		33

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

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	\$ 128,301	\$ 863	\$ 12,830	\$ 11,967	10	\$ 29,005	71
72	Current Year Purchases	212,241	14,846	21,026	6,180	10	21,026	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 340,541	\$ 15,709	\$ 33,857	\$ 18,148		\$ 50,031	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)	\$ 583,651	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 15,777	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 45,372	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 29,595	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 64,206	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 Norridge Gardens

# 0052431

Report Period Beginning: 01/01/14

Ending: 12/31/14

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: FNR Norridge

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:		292		\$ 3,398,610			3
4	Additions							4
5								5
6	Allocated from Premier HC Management				37,834			6
7	TOTAL		292		\$ 3,436,444			7

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. \_\_\_\_\_ /2015                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2016                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2017                      \$ \_\_\_\_\_

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: \_\_\_\_\_ \*

**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: \$ 1,043

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					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.

**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.)

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
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**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
1. From this facility		
2. From other facilities (f)		
<b>TOTAL TRAINED</b>		

(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.)

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	787,211	\$		\$	787,211	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				396,304				396,304	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				1,112,719				1,112,719	4
5	Physician Care	39 - 03	visits				9,663				9,663	5
6	Dental Care	39 - 03	visits				6,250				6,250	6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescripts					799,562			799,562	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): <u>See Supplemental</u>						59,436	161,616			221,052	13
14	TOTAL			\$		\$	2,371,583	\$	961,178	\$	3,332,761	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 Norridge Gardens# 0052431Report Period Beginning: 01/01/14

Ending:

12/31/14

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 2,605,836	\$	1
2	Cash-Patient Deposits	57,140		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	5,981,799		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	35,916		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 8,680,691	\$	10
	<b>B. Long-Term Assets</b>			
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	247,872		15
16	Equipment, at Historical Cost	370,515		16
17	Accumulated Depreciation (book methods)	(6,037)		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):	5,680,430		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 6,292,780	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 14,973,471	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 6,465,647	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	76,375		28
29	Short-Term Notes Payable	87,463		29
30	Accrued Salaries Payable	680,029		30
31	Accrued Taxes Payable (excluding real estate taxes)	226,127		31
32	Accrued Real Estate Taxes(Sch.IX-B)	297,810		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	See Attached Schedule	751,512		36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 8,584,963	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	711,419		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	See Attached Schedule	1,269,713		43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 1,981,132	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 10,566,095	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 4,407,376	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 14,973,471	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 1,399,453	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 1,399,453	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	3,007,923	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 3,007,923	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 4,407,376	24 *

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

**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.

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 25,647,015	1
2	Discounts and Allowances for all Levels	34,848	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 25,681,863</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	415,920	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 415,920</b>	8
<b>C. Other Operating Revenue</b>			
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	92,599	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 92,599</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,008	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 1,008</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>		29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 26,191,390</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,720,426	31
32	Health Care	7,315,449	32
33	General Administration	4,547,180	33
<b>B. Capital Expense</b>			
34	Ownership	4,409,636	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	3,590,767	35
36	Provider Participation Fee	600,009	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 23,183,467</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>3,007,923</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 3,007,923</b>	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 9,327,844	44
45	Private Pay - Net Inpatient Revenue	3,046,839	45
46	Medicare - Net Inpatient Revenue	12,473,241	46
47	Other-(specify) <u>Insurance</u>	780,022	47
48	Other-(specify) <u>Hospice</u>	53,917	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 25,681,863</b>	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

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

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

Facility Name & ID Number Norridge Gardens

# 0052431

Report Period Beginning:

01/01/14

Ending:

12/31/14

**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	2,478	2,528	\$ 141,186	\$ 55.85	1
2	Assistant Director of Nursing	13,528	13,801	454,187	32.91	2
3	Registered Nurses	61,597	66,283	1,715,618	25.88	3
4	Licensed Practical Nurses	34,180	35,573	864,315	24.30	4
5	CNAs & Orderlies	211,152	219,593	2,330,273	10.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	22,912	23,862	439,052	18.40	8
9	Activity Director	23,478	24,837	327,454	13.18	9
10	Activity Assistants					10
11	Social Service Workers	14,525	15,311	240,693	15.72	11
12	Dietician					12
13	Food Service Supervisor	3,666	4,026	104,664	26.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	51,668	53,755	598,632	11.14	15
16	Dishwashers					16
17	Maintenance Workers	6,245	6,959	112,848	16.22	17
18	Housekeepers	1,814	1,814	15,769	8.69	18
19	Laundry	673	673	6,846	10.17	19
20	Administrator	4,013	4,160	204,668	49.20	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,167	20,203	354,135	17.53	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	6,859	7,733	115,454	14.93	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	8,276	8,799	213,915	24.31	33
34	TOTAL (lines 1 - 33)	487,231	509,910	\$ 8,239,709 *	\$ 16.16	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	Monthly	\$ 19,761	01-03	35
36	Medical Director	Monthly	42,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	4,080	10-03	38
39	Pharmacist Consultant	Monthly	21,156	10-03	39
40	Physical Therapy Consultant	Monthly	22,000	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,864	11-03	44
45	Social Service Consultant	Monthly	5,920	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 117,781		49

**C. CONTRACT NURSES**

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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Safet Keljalic	Administrator	0	\$ 165,781	Workers' Compensation Insurance	\$ 173,765	IDPH License Fee	\$ 3,980		
Brian Gallagher	Asst. Admin.	0	38,887	Unemployment Compensation Insurance	127,492	Advertising: Employee Recruitment	13,853		
				FICA Taxes	600,529	Health Care Worker Background Check			
				Employee Health Insurance	622,008	(Indicate # of checks performed <u>369</u> )	3,690		
				Employee Meals	1,473	Patient Background Checks	247		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	84		
				Pension Contributions	29,336	Licenses & Permits	4,974		
				Other Employee Benefits	53,493	Allocated from Premier HC Management	23		
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$ 204,668						
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description	Amount			Description	Line #	Amount	Description	Amount	
Premier Healthcare Management	\$ 1,345,287						Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 1,345,287	TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,608,096	TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)									
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description	Amount	
Frost, Ruttenberg & Rothblatt	Accounting	\$ 14,125							
Richard Peelo & Associates	Accounting	4,200							
See Attached	Legal Fees	17,372							
Ability Network	Data Processing	2,343							
ADP	Data Processing	54,958							
Singer Network	Data Processing	37,435							
Emdeon Business Services	Data Processing	959							
HDSI	Data Processing	7,435							
IIT/Sourcetechn	Data Processing	1,380							
Sigma Care	Data Processing	73,836							
Bylmas	Tax Credit	209							
See Supplemental Schedule		18,054							
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	Seminar Expense	
(For legal fee disclosure, see page 39 of instructions)			\$ 232,304					(agree to Sch. V, line 24, col. 8)	
								TOTAL	
								\$ 10,493	

\* Attach copy of IMRF notifications

\*\*See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Norridge Gardens# 0052431

Report Period Beginning:

01/01/14

Ending:

12/31/14**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? No  
If YES, give association name and amount. N/A
- (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? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 138,239 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 600,009  
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. \$ 1,473 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14  
d. Have vehicle usage logs been maintained? 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? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees.