

Facility Name & ID Number Park Ridge Care Center

0039255 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	46	Skilled (SNF)	46	16,790	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	46	TOTALS	46	16,790	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	501		941	1,442	8
9	SNF/PED					9
10	ICF	11,395		1,651	13,046	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,896		2,592	14,488	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.29%

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? Yes

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 12/1/1993

J. Was the facility purchased or leased after January 1, 1978?
YES Date 12/1/1993 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 46 and days of care provided 941

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number

Park Ridge Care Center

0039255

Report Period Beginning:

01/01/15

Ending:

12/31/15

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
	A. General Services										
1	Dietary	168,917	11,195	805	180,917		180,917		180,917		1
2	Food Purchase		65,945		65,945	(548)	65,398		65,398		2
3	Housekeeping	62,101	10,690		72,791		72,791		72,791		3
4	Laundry	40,483	6,823		47,306		47,306		47,306		4
5	Heat and Other Utilities			36,408	36,408		36,408	(472)	35,936		5
6	Maintenance	43,105	26,330	33,715	103,150		103,150	12,121	115,271		6
7	Other (specify):*							81	81		7
8	TOTAL General Services	314,606	120,983	70,928	506,517	(548)	505,970	11,730	517,700		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	892,825	49,078	3,093	944,996		944,996		944,996		10
10a	Therapy										10a
11	Activities		6,042	994	7,036		7,036		7,036		11
12	Social Services			2,126	2,126		2,126		2,126		12
13	CNA Training										13
14	Program Transportation			80	80		80		80		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	892,825	55,120	12,293	960,238		960,238		960,238		16
	C. General Administration										
17	Administrative	118,998			118,998		118,998	19,085	138,083		17
18	Directors Fees										18
19	Professional Services			72,893	72,893		72,893	(34,916)	37,977		19
20	Dues, Fees, Subscriptions & Promotions			21,007	21,007		21,007	(4,851)	16,156		20
21	Clerical & General Office Expenses	16,092	7,792	278,677	302,561		302,561	(235,032)	67,529		21
22	Employee Benefits & Payroll Taxes			173,510	173,510	548	174,058		174,058		22
23	Inservice Training & Education										23
24	Travel and Seminar			630	630		630	957	1,587		24
25	Other Admin. Staff Transportation			3,494	3,494		3,494	792	4,286		25
26	Insurance-Prop.Liab.Malpractice			59,568	59,568		59,568	4,106	63,674		26
27	Other (specify):*							8,287	8,287		27
28	TOTAL General Administration	135,090	7,792	609,779	752,661	548	753,209	(241,571)	511,637		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,342,521	183,895	693,000	2,219,416		2,219,416	(229,841)	1,989,575		29

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

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

Facility Name & ID Number

Park Ridge Care Center

#0039255

Report Period Beginning:

01/01/15

Ending:

12/31/15

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			23,062	23,062		23,062	58,614	81,676			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							110,426	110,426			32
33	Real Estate Taxes							199,718	199,718			33
34	Rent-Facility & Grounds			360,000	360,000		360,000	(360,000)				34
35	Rent-Equipment & Vehicles			6,103	6,103		6,103	3,916	10,019			35
36	Other (specify):*							5,923	5,923			36
37	TOTAL Ownership			389,165	389,165		389,165	18,597	407,762			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		18,161	124,312	142,473		142,473		142,473			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			107,416	107,416		107,416		107,416			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		18,161	231,728	249,889		249,889		249,889			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,342,521	202,056	1,313,893	2,858,470		2,858,470	(211,244)	2,647,226			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:

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Ending:

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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	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(850)	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	(14,133)	30		9
10	Interest and Other Investment Income	(130)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		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	(468)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(95,500)	21		24
25	Fund Raising, Advertising and Promotional	(908)	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	(226,952)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (338,941)		\$	30

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	
		Amount	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)	127,697		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 127,697		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (211,244)		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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY

48		49		50		51		52	
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Park Ridge Care Center

ID# 0039255

Report Period Beginning: 01/01/15

Ending: 12/31/15

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Sequestration Expense	\$ (11,286)	21	1
2	Bank Charges	(2,352)	21	2
3	Building Co. - Accounting Fee	(11,242)	19	3
4	Building Co. - Entity Expense	(564)	21	4
5	Additional R&M	9,323	06	5
6	PPA - Office Expenses	(9,222)	21	6
7	PPA - Various w/o accounts	(152,115)	21	7
8	PAC Dues	(4,939)	20	8
9	Building Co. - Capitalized R&M	(44,556)	06	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
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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	(226,952)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park Ridge Care Center# 0039255

Report Period Beginning:

01/01/15

Ending:

12/31/15

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													2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(850)		378									(472)	5
6	Maintenance	(35,233)	44,556	2,798									12,121	6
7	Other (specify):*			81									81	7
8	TOTAL General Services	(36,083)	44,556	3,257									11,730	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative				19,085								19,085	17
18	Directors Fees													18
19	Professional Services	(11,242)	11,242	(34,916)									(34,916)	19
20	Fees, Subscriptions & Promotions	(5,847)		996									(4,851)	20
21	Clerical & General Office Expenses	(271,507)	564	32,525	3,386								(235,032)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			957									957	24
25	Other Admin. Staff Transportation			792									792	25
26	Insurance-Prop.Liab.Malpractice		2,990	1,116									4,106	26
27	Other (specify):*			4,940		3,347							8,287	27
28	TOTAL General Administration	(288,595)	14,796	6,410	22,471	3,347							(241,571)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(324,678)	59,352	9,667	22,471	3,347							(229,841)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	(14,133)	71,829	918									58,614	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(130)	109,791	765									110,426	32
33	Real Estate Taxes		198,287	1,431									199,718	33
34	Rent-Facility & Grounds		(360,000)										(360,000)	34
35	Rent-Equipment & Vehicles			3,916									3,916	35
36	Other (specify):*		5,923										5,923	36
37	TOTAL Ownership	(14,263)	25,830	7,030									18,597	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(338,941)	85,182	16,697	22,471	3,347							(211,244)	45

Facility Name & ID Number

Park Ridge Care Center

0039255

Report Period Beginning:

01/01/15

Ending:

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VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

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)	
1	V	34 Rental Income	\$ 360,000	665 Busse Highway Limited Partnership		\$	\$ (360,000)	1
2	V	32 Interest Income	136	665 Busse Highway Limited Partnership			(136)	2
3	V	32 Interest Expense - Mortgage		665 Busse Highway Limited Partnership		74,220	74,220	3
4	V	30 Depreciation		665 Busse Highway Limited Partnership		71,829	71,829	4
5	V	36 MIP Insurance		665 Busse Highway Limited Partnership		5,923	5,923	5
6	V	33 Real Estate Taxes		665 Busse Highway Limited Partnership		198,287	198,287	6
7	V	06 Repairs and Maintenance		665 Busse Highway Limited Partnership		44,556	44,556	7
8	V	26 Insurance		665 Busse Highway Limited Partnership		2,990	2,990	8
9	V	32 Interest Expense - Other		665 Busse Highway Limited Partnership		35,707	35,707	9
10	V	19 Accounting		665 Busse Highway Limited Partnership		11,242	11,242	10
11	V	21 Entity Expense		665 Busse Highway Limited Partnership		564	564	11
12	V							12
13	V							13
14	Total		\$ 360,136			\$ 445,318	\$ * 85,182	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	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 378	\$	378	15
16	V	6 REPAIRS & MAINT.		DYNAMIC HEALTH CARE CONS.	100.00%	2,798		2,798	16
17	V	7 EMP. BEN-GEN SERV.		DYNAMIC HEALTH CARE CONS.	100.00%	81		81	17
18	V	19 PROFESSIONAL FEES		DYNAMIC HEALTH CARE CONS.	100.00%	1,084		1,084	18
19	V	20 DUES AND SUBSCRIPTIONS		DYNAMIC HEALTH CARE CONS.	100.00%	996		996	19
20	V	21 CLERICAL & GENERAL		DYNAMIC HEALTH CARE CONS.	100.00%	32,525		32,525	20
21	V	24 SEMINARS AND TRAVEL		DYNAMIC HEALTH CARE CONS.	100.00%	957		957	21
22	V	25 AUTO EXP.		DYNAMIC HEALTH CARE CONS.	100.00%	792		792	22
23	V	26 INSURANCE		DYNAMIC HEALTH CARE CONS.	100.00%	1,116		1,116	23
24	V	27 EMP.BEN. - GEN. ADMIN.		DYNAMIC HEALTH CARE CONS.	100.00%	4,940		4,940	24
25	V	30 DEPRECIATION		DYNAMIC HEALTH CARE CONS.	100.00%	918		918	25
26	V	32 INTEREST		DYNAMIC HEALTH CARE CONS.	100.00%	765		765	26
27	V	33 REAL ESTATE TAXES		DYNAMIC HEALTH CARE CONS.	100.00%	1,431		1,431	27
28	V	19 REAL ESTATE TAX PROTEST FEES		DYNAMIC HEALTH CARE CONS.	100.00%				28
29	V	35 AUTO RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	3,889		3,889	29
30	V	35 EQUIPMENT RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	27		27	30
31	V								31
32	V	19 HOME OFFICE	36,000	DYNAMIC HEALTH CARE CONS.	100.00%			(36,000)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 36,000			\$ 52,697	\$ *	16,697	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	6 MAINT. CMP. - D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$		15
16	V	17 ADMIN. CMP. - M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	7,487	7,487	16
17	V	17 ADMIN. CMP. - M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			17
18	V	17 ADMIN. CMP. - F. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			18
19	V	17 ADMIN. CMP. - D. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			19
20	V	17 ADMIN. CMP. - S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%			20
21	V	17 ADMIN. CMP. - B. FRIEDMAN		DYNAMIC HEALTH CARE CONS.	100.00%			21
22	V	17 ADMIN. CMP. - R. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			22
23	V	17 ADMIN. CMP. - S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%			23
24	V	17 ADMIN. CMP. - D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%			24
25	V	17 ADMIN. CMP. - H. ALTER		DYNAMIC HEALTH CARE CONS.	100.00%			25
26	V	17 ADMIN. CMP. - V. DAVIS (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	4,297	4,297	26
27	V	17 ADMIN. CMP. - A. CASSATA (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%			27
28	V	17 ADMIN. CMP. - VAR. (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%			28
29	V	17 ADMIN. CMP. - CFO (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	7,301	7,301	29
30	V	21 CLERICAL CMP. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	3,144	3,144	30
31	V	21 CLERICAL CMP. - E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	242	242	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 22,471	\$ * 22,471	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	7 EMP. BEN.- D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$		15
16	V	27 EMP. BEN.- M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	431	431	16
17	V	27 EMP. BEN.- M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			17
18	V	27 EMP. BEN.- F. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			18
19	V	27 EMP. BEN.- D. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			19
20	V	27 EMP. BEN.- S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%			20
21	V	27 EMP. BEN.- B. FRIEDMAN		DYNAMIC HEALTH CARE CONS.	100.00%			21
22	V	27 EMP. BEN.- R. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			22
23	V	27 EMP. BEN.- S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%			23
24	V	27 EMP. BEN.- D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%			24
25	V	27 EMP. BEN.- H. ALTER		DYNAMIC HEALTH CARE CONS.	100.00%			25
26	V	27 EMP. BEN.-V. DAVIS (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	1,201	1,201	26
27	V	27 EMP. BEN.-A. CASSATA (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%			27
28	V	27 EMP. BEN.- NON-OWNER		DYNAMIC HEALTH CARE CONS.	100.00%			28
29	V	27 EMP. BEN.- CFO (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	928	928	29
30	V	27 EMP. BEN. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	647	647	30
31	V	27 EMP. BEN. - E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	140	140	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 3,347	\$ * 3,347	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: 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	Total		\$			\$	\$ *	39

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

Facility Name & ID Number

Park Ridge Care Center

0039255

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	Total		\$			\$	\$ *	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: 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	Total		\$			\$	\$ *	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: 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	Total		\$			\$	\$ *	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	Total		\$			\$	\$ *	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: 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	Total		\$			\$	\$ *	39

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

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Marshall Mauer	Relative	Administrative	0%	See Attached	1.50	3.00%	Alloc. Salary	\$ 7,487	17-07	1	
2	Esther Maryles	Relative	Administrative	0%	See Attached	0.10	0.36%	Alloc. Salary	242	21-07	2	
3											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	\$ 7,729		13	

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

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

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/15

Ending: 12/31/15

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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

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	407,367	13	\$ 10,618	\$ 14,488	\$ 378	1	
2	6	REPAIRS & MAINT.	PATIENT DAYS	407,367	13	78,675	35,168	14,488	2,798	2
3	7	EMP. BEN-GEN SERV.	PATIENT DAYS	407,367	13	2,289	14,488	81	3	
4	19	PROFESSIONAL FEES	PATIENT DAYS	407,367	13	30,482	14,488	1,084	4	
5	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	407,367	13	27,992	14,488	996	5	
6	21	CLERICAL & GENERAL	PATIENT DAYS	407,367	13	914,524	670,657	14,488	32,525	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	407,367	13	26,915	14,488	957	7	
8	25	AUTO EXP.	PATIENT DAYS	407,367	13	22,263	14,488	792	8	
9	26	INSURANCE	PATIENT DAYS	407,367	13	31,386	14,488	1,116	9	
10	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	407,367	13	138,888	14,488	4,940	10	
11	30	DEPRECIATION	PATIENT DAYS	407,367	13	25,822	14,488	918	11	
12	32	INTEREST	PATIENT DAYS	407,367	13	21,500	14,488	765	12	
13	33	REAL ESTATE TAXES	PATIENT DAYS	407,367	13	40,240	14,488	1,431	13	
14	19	REAL ESTATE TAX PROTEST	PATIENT DAYS	407,367	13		14,488		14	
15	35	AUTO RENTAL	PATIENT DAYS	407,367	13	109,345	14,488	3,889	15	
16	35	EQUIPMENT RENTAL	PATIENT DAYS	407,367	13	770	14,488	27	16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,481,709	\$ 705,825	\$ 52,697	25	

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

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	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	9	59,373	59,373	-	1
2	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	11	200,000	200,000	1.50	7,487
3	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	9	200,000	200,000	-	3
4	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	5	5,500	5,500	-	4
5	17	ADMIN. CMP. - D. AARON	WGHTD. AVG. HOURS	40	3	64,041	64,041	-	5
6	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	133,279	133,279	-	6
7	17	ADMIN. CMP. - B. FRIEDMAN	WGHTD. AVG. HOURS	40	1	200,000	200,000	-	7
8	17	ADMIN. CMP. - R. AARON	WGHTD. AVG. HOURS	40	1	15,271	15,271	-	8
9	17	ADMIN. CMP. - S. HARAMARA	WGHTD. AVG. HOURS	30	3	75,266	75,266	-	9
10	17	ADMIN. CMP. - D. KUFTA	WGHTD. AVG. HOURS	50	8	147,459	147,459	-	10
11	17	ADMIN. CMP. - H. ALTER	WGHTD. AVG. HOURS	40	1	12,000	12,000	-	11
12	17	ADMIN. CMP. - V. DAVIS (NON-	WGHTD. AVG. HOURS	40	10	114,789	114,789	1.50	4,297
13	17	ADMIN. CMP. - A. CASSATA (N	WGHTD. AVG. HOURS	40	1	68,028	68,028	-	13
14	17	ADMIN. CMP. - VAR. (NON-OW	WGHTD. AVG. HOURS	45	8	130,998	130,998	-	14
15	17	ADMIN. CMP. - CFO (NON-OW)	WGHTD. AVG. HOURS	40	10	195,028	195,028	1.50	7,301
16	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	10	83,832	83,832	1.50	3,144
17	21	CLERICAL CMP. - E. MARYLE	WGHTD. AVG. HOURS	28	11	64,541	64,541	0.10	242
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,769,405	\$ 1,769,407	\$	22,471

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

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	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40	9	6,168			1
2	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	11	11,514	1.50	431	2
3	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	9	14,139			3
4	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	5	39,260			4
5	27	EMP. BEN.- D. AARON	WGHTD. AVG. HOURS	40	3	5,167			5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	35,129			6
7	27	EMP. BEN.- B. FRIEDMAN	WGHTD. AVG. HOURS	40	1	10,844			7
8	27	EMP. BEN.- R. AARON	WGHTD. AVG. HOURS	40	1	1,340			8
9	27	EMP. BEN.- S. HARAMARAS	WGHTD. AVG. HOURS	30	3	27,046			9
10	27	EMP. BEN.- D. KUFTA	WGHTD. AVG. HOURS	50	8	10,501			10
11	27	EMP. BEN.- H. ALTER	WGHTD. AVG. HOURS	40	1	1,078			11
12	27	EMP. BEN.-V. DAVIS (NON-OW	WGHTD. AVG. HOURS	40	10	32,072	1.50	1,201	12
13	27	EMP. BEN.-A. CASSATA (NON-OW	WGHTD. AVG. HOURS	40	1	5,480			13
14	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	8	43,223			14
15	27	EMP. BEN.- CFO (NON-OWNER)	WGHTD. AVG. HOURS	40	10	24,786	1.50	928	15
16	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	10	17,251	1.50	647	16
17	27	EMP. BEN. - E. MARYLES	WGHTD. AVG. HOURS	28	11	37,525	0.10	140	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 322,523	\$	\$ 3,347	25

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/15

Ending: 12/31/15

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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/15

Ending: 12/31/15

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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/15

Ending: 12/31/15

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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/15

Ending: 12/31/15

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	TOTALS				\$	\$		\$	25

Facility Name & ID Number **Park Ridge Care Center**

0039255 Report Period Beginning: **01/01/15** Ending: **12/31/15**

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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/15

Ending: 12/31/15

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	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Park Ridge Care Center

0039255

Report Period Beginning:

01/01/15

Ending:

12/31/15

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										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Midland		X	Mortgage			\$	\$ 1,302,638		\$ 109,927	1								
2	Allocated from Dynamic									765	2								
3											3								
4											4								
5											5								
Working Capital																			
6											6								
7											7								
8											8								
9	TOTAL Facility Related						\$	\$ 1,302,638		\$ 110,692	9								
B. Non-Facility Related*																			
10	Interest Income		X							(130)	10								
11	Interest Income-Bldg Co.		X							(136)	11								
12											12								
13											13								
14	TOTAL Non-Facility Related						\$	\$		\$ (266)	14								
15	TOTALS (line 9+line14)						\$	\$ 1,302,638		\$ 110,426	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 5,923 Line # 36

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

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

Facility Name & ID Number

Park Ridge Care Center

0039255

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	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							\$	\$			\$	1								
2												2								
3												3								
4												4								
5												5								
6												6								
7	TOTAL Long-Term																			
	Working Capital																			
8							\$	\$			\$	8								
9												9								
10												10								
11												11								
12												12								
13												13								
14	TOTAL Working Capital																			
	B. Non-Facility Related*																			
15							\$	\$			\$	15								
16												16								
17												17								
18												18								
19												19								
20	TOTAL Non-Facility Related																			

* 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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1. Real Estate Tax accrual used on 2014 report.		\$	182,000	1															
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	189,718	2															
3. Under or (over) accrual (line 2 minus line 1).		\$	7,718	3															
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	192,000	4															
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		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.		\$	199,718	7															
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2010	<u>137,418</u>	<u>8</u>	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2014 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2014 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2014 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2011	<u>139,204</u>	<u>9</u>																
	2012	<u>146,366</u>	<u>10</u>																
	2013	<u>178,350</u>	<u>11</u>																
	2014	<u>188,287</u>	<u>12</u>																
2015 Accrual - \$188,287 x 1.02 = \$192,053 (Rounded)																			
Allocated from Dynamic - \$1,431																			

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.

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/15

Ending:

12/31/15

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 (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	<u>Facility</u>			\$ <u>49,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 49,000	3

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	46	1986	1986	\$ 1,323,000	\$ 71,829	39	\$ 33,923	\$ (37,906)	\$ 747,720	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1994	8,310		20			7,378	9
10	Various		1995	33,691		20	798	798	30,763	10
11	Various		1997	21,547		20	1,077	1,077	19,146	11
12	Various		1998	18,893		20	945	945	16,285	12
13	Various		1999	7,527		20	376	376	6,200	13
14	Various		2000	68,323		20	3,376	3,376	52,388	14
15	Various		2001	3,525		20	81	81	3,058	15
16	Various		2002	5,638		20	185	185	4,436	16
17	Various		2003	24,130		20	436	436	21,451	17
18	Various		2004	3,490		20	175	175	1,998	18
19	Various		2005	1,858		20	93	93	970	19
20	Various		2006	6,500		20	325	325	3,008	20
21	Various		2008	11,545		20	752	752	7,416	21
22	Various		2010	6,813		20	273	273	1,511	22
23	Various		2011	11,965		20	307	307	1,312	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 Park Ridge Care Center

0039255

Report Period Beginning:

01/01/15

Ending:

12/31/15

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		285,804			14,290	14,290	76,525	67
68		15,777	405		451	46	10,067	68
69			23,062			(23,062)		69
70		\$ 1,858,337	\$ 95,296		\$ 57,863	\$ (37,433)	\$ 1,011,632	70

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

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	Totals from Page 12A, Carried Forward		\$ 1,858,337	\$ 95,296		\$ 57,863	\$ (37,433)	\$ 1,011,632	1
2	Replace Sprinkler Heads	2012	4,750		20	122	122	462	2
3	Fire Alarm System	2012	20,310		20	521	521	1,931	3
4	Sprinkler System Hydraulic Placard	2013	5,920		20	152	152	436	4
5	Replace Gutters & Repair Roof Covering	2014	4,300		20	110	110	188	5
6	Security Cameras	2014	2,580		20	369	369	584	6
7	Laundry, Hallway, Kitchen-Remove & Install Stud Walls, Fire Ra	2014	19,625		20	503	503	734	7
8	Remodeling Supplies - Window Installation	2014	2,760		20	552	552	736	8
9	Tuckpointing/Painting	2014	5,000		20	1,000	1,000	1,333	9
10	Install Fire Prevention Device	2015	4,300		20	92	92	92	10
11	Masonry Concrete-Sidewalk/Patio	2015	5,500		20	65	65	65	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)		\$ 1,933,382	\$ 95,296		\$ 61,349	\$ (33,947)	\$ 1,018,194	34

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

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		\$ 1,933,382	\$ 95,296		\$ 61,349	\$ (33,947)	\$ 1,018,194	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		\$ 1,933,382	\$ 95,296		\$ 61,349	\$ (33,947)	\$ 1,018,194	34

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

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		\$ 1,933,382	\$ 95,296		\$ 61,349	\$ (33,947)	\$ 1,018,194	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		\$ 1,933,382	\$ 95,296		\$ 61,349	\$ (33,947)	\$ 1,018,194	34

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

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/15

Ending:

12/31/15

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		\$ 1,933,382	\$ 95,296		\$ 61,349	\$ (33,947)	\$ 1,018,194	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		\$ 1,933,382	\$ 95,296		\$ 61,349	\$ (33,947)	\$ 1,018,194	34

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

Facility Name & ID Number Park Ridge Care Center# 0039255

Report Period Beginning:

01/01/15

Ending:

12/31/15**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	Building Company		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Flooring	2008	14,000		20	700	700	6,883	9
10	Nursing Station	2008	5,000		20	250	250	2,417	10
11	Nursing Station	2008	4,700		20	235	235	2,272	11
12	Econocare Call Light System	2008	12,011		20	601	601	6,208	12
13	Jacks & Son Asphalt Parking Lot	2008	16,033		20	802	802	7,484	13
14	Flooring	2008	15,578		20	779	779	7,011	14
15	Drop Ceiling & Lighting	2009	19,000		20	950	950	8,233	15
16	Roof Rubber Installation	2009	3,000		20	150	150	1,225	16
17	Lobby - Wallpaper, Vinyl Tile, Millwork, Cove Base	2010	4,185		20	209	209	1,254	17
18	Conference Room - Wallpaper, Vinyl Tile, Millwork, Cove Base	2010	3,909		20	195	195	1,170	18
19	Corridor - Wallpaper, Vinyl Tile, Millwork, Cove Base	2010	19,821		20	991	991	5,946	19
20	Various Areas: Wallcovering, Vinyl Flr, Paint (Drs, Drframes, & V	2010	48,069		20	2,403	2,403	14,419	20
21	Door	2011	11,077		20	554	554	2,770	21
22	Double Entry Kitchen Door	2011	3,450		20	173	173	865	22
23	Built-In Cabinet and Countertop	2011	6,775		20	339	339	1,695	23
24	Remodeling of 2 Bathrooms	2013	19,965		20	998	998	1,996	24
25	Roof Replacement	2013	14,300		20	715	715	1,430	25
26	Remove/Replace floor tile with Ceramic Tile in Kitchen	2015	5,875		20	294	294	294	26
27	Kitchen Hood	2015	14,500		20	725	725	725	27
28	Remove/Replace Basement Walls	2015	11,875		20	594	594	594	28
29	Kitchen Floor Tiel, Replace Pipes, Countertop	2015	32,681		20	1,634	1,634	1,634	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 285,804	\$		\$ 14,290	\$ 14,290	\$ 76,525	34

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

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/15

Ending:

12/31/15

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		\$ 285,804	\$		\$ 14,290	\$ 14,290	\$ 76,525	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)	\$ 285,804	\$		\$ 14,290	\$ 14,290	\$ 76,525	34

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

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Dynamic	1993	15,777	405	20	451	46	10,067	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 15,777	\$ 405		\$ 451	\$ 46	\$ 10,067	34

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

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/15

Ending:

12/31/15

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		\$ 15,777	\$ 405		\$ 451	\$ 46	\$ 10,067	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)	\$ 15,777	\$ 405		\$ 451	\$ 46	\$ 10,067	34

**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	\$ 121,007	\$ 380	\$ 19,003	\$ 18,623	10	\$ 95,718	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	192,664				10	192,629	73
74								74
75	TOTALS	\$ 313,671	\$ 380	\$ 19,003	\$ 18,623		\$ 288,348	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Dynamic	2015	\$ 8,382	\$ 133	\$ 1,324	\$ 1,191	5	\$ 6,616	76
77										77
78										78
79										79
80	TOTALS			\$ 8,382	\$ 133	\$ 1,324	\$ 1,191		\$ 6,616	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)	\$ 2,304,435	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 95,809	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 81,676	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (14,133)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,313,157	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

		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: _____ *

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 3,085 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	Facility	2015 Buick Enclave	\$ 525.00	\$ 3,045	17
18	Allocated from Dynamic			3,889	18
19					19
20					20
21	TOTAL		\$ 525.00	\$ 6,934	21

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. 2016 \$ _____

13. 2017 \$ _____

14. 2018 \$ _____

* 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>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <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>2. <u>CLASSROOM PORTION:</u></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>3. <u>CLINICAL PORTION:</u></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	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.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	Cost												
1	Licensed Occupational Therapist	39 - 03	hrs	\$			\$	59,234	\$			\$	59,234			1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					1,993							1,993	2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39 - 03	hrs					61,112							61,112	4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy	39 - 02	# of prescripts							16,503					16,503	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>							1,973		1,658					3,631	13
14	TOTAL			\$			\$	124,312	\$	18,161		\$	142,473			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 Park Ridge Care Center

0039255

Report Period Beginning: 01/01/15

Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 402,457	\$ 490,771	1
2	Cash-Patient Deposits	66,408	66,408	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	689,773	689,773	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	41,676	47,232	6
7	Other Prepaid Expenses	6,435	6,435	7
8	Accounts Receivable (owners or related parties)	31,390	240,153	8
9	Other(specify):	19,525	423,954	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,257,664	\$ 1,964,726	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	399,102	596,471	15
16	Equipment, at Historical Cost	177,676	366,966	16
17	Accumulated Depreciation (book methods)	(391,266)	(1,410,554)	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):	9,348	109,168	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 194,860	\$ 1,034,051	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,452,524	\$ 2,998,777	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 101,522	\$ 101,524	26
27	Officer's Accounts Payable	44,465	32,500	27
28	Accounts Payable-Patient Deposits	66,408	66,408	28
29	Short-Term Notes Payable		26,871	29
30	Accrued Salaries Payable	126,938	126,938	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,545	4,545	31
32	Accrued Real Estate Taxes(Sch.IX-B)		192,000	32
33	Accrued Interest Payable		4,885	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)	\$ 343,878	\$ 555,671	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,275,766	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)	\$	\$ 1,275,766	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 343,878	\$ 1,831,437	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,108,646	\$ 1,167,340	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,452,524	\$ 2,998,777	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,283,090	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,283,089	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(114,443)	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)	\$ (174,443)	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)	\$ 1,108,646	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning: 01/01/15

Ending:

12/31/15

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		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,650,490	1
2	Discounts and Allowances for all Levels	(398,649)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,251,841	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	405,650	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 405,650	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	25,320	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,050	19
20	Radiology and X-Ray	559	20
21	Other Medical Services	3,477	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 33,406	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	130	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 130	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	53,000	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 53,000	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,744,027	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	506,517	31
32	Health Care	960,238	32
33	General Administration	752,661	33
B. Capital Expense			
34	Ownership	389,165	34
C. Ancillary Expense			
35	Special Cost Centers	142,473	35
36	Provider Participation Fee	107,416	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,858,470	40
41	Income before Income Taxes (line 30 minus line 40)**	(114,443)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (114,443)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,987,286	44
45	Private Pay - Net Inpatient Revenue	(4,110)	45
46	Medicare - Net Inpatient Revenue	161,902	46
47	Other-(specify) <u>Hospice</u>	106,763	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,251,841	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 **Park Ridge Care Center**

0039255

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	3,193	3,426	\$ 141,875	\$ 41.41	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,490	8,182	246,598	30.14	3
4	Licensed Practical Nurses	1,575	1,595	33,555	21.04	4
5	CNAs & Orderlies	31,902	34,284	468,993	13.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,270	2,527	56,278	22.27	13
14	Head Cook	6,304	6,694	95,819	14.31	14
15	Cook Helpers/Assistants	1,476	1,543	16,820	10.90	15
16	Dishwashers					16
17	Maintenance Workers	2,004	2,101	43,105	20.52	17
18	Housekeepers	5,288	5,697	62,101	10.90	18
19	Laundry	2,863	3,090	40,483	13.10	19
20	Administrator	2,062	2,266	118,998	52.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,104	1,117	16,092	14.41	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	117	121	1,804	14.91	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	67,648	72,643	\$ 1,342,521 *	\$ 18.48	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	10	\$ 805	01-03	35
36	Medical Director	96	6,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	3,093	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	19	994	11-03	44
45	Social Service Consultant	34	2,126	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	207	\$ 13,018		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

Facility Name & ID Number Park Ridge Care Center# 0039255

Report Period Beginning:

01/01/15

Ending:

12/31/15**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 - \$14,968
- (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. \$ 19,433 Line 10-02
- (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. \$ 107,416
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. \$ 548 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? No
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.