

Facility Name & ID Number Park Ridge Care Center

0039255 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	44		1,033	1,077	8
9	SNF/PED					9
10	ICF	11,870		1,765	13,635	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,914		2,798	14,712	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.62%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve days in Section B.)

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

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

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

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 1,033

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	168,483	11,522	600	180,605		180,605		180,605		1
2	Food Purchase		64,676		64,676	(529)	64,147		64,147		2
3	Housekeeping	65,673	14,534		80,207		80,207		80,207		3
4	Laundry	45,065	8,448		53,513		53,513		53,513		4
5	Heat and Other Utilities			36,597	36,597		36,597	(306)	36,291		5
6	Maintenance	46,395	24,572	27,597	98,564		98,564	34,707	133,271		6
7	Other (specify):*							87	87		7
8	TOTAL General Services	325,616	123,752	64,794	514,162	(529)	513,633	34,488	548,121		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	963,715	60,105	6,923	1,030,743		1,030,743	(332)	1,030,411		10
10a	Therapy										10a
11	Activities	66,645	7,565	689	74,899		74,899		74,899		11
12	Social Services			1,430	1,430		1,430		1,430		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,030,360	67,670	15,042	1,113,072		1,113,072	(332)	1,112,740		16
	C. General Administration										
17	Administrative	131,520			131,520		131,520	27,169	158,689		17
18	Directors Fees										18
19	Professional Services			97,043	97,043	(17,906)	79,137	(35,792)	43,345		19
20	Dues, Fees, Subscriptions & Promotions			15,874	15,874		15,874	(3,484)	12,390		20
21	Clerical & General Office Expenses		11,512	316,393	327,905		327,905	(255,799)	72,106		21
22	Employee Benefits & Payroll Taxes			184,586	184,586	529	185,115	(925)	184,190		22
23	Inservice Training & Education										23
24	Travel and Seminar			350	350		350	144	494		24
25	Other Admin. Staff Transportation			4,201	4,201		4,201	1,472	5,673		25
26	Insurance-Prop.Liab.Malpractice			77,121	77,121		77,121	3,924	81,045		26
27	Other (specify):*							11,833	11,833		27
28	TOTAL General Administration	131,520	11,512	695,568	838,600	(17,376)	821,224	(251,458)	569,766		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,487,496	202,934	775,404	2,465,834	(17,906)	2,447,928	(217,302)	2,230,627		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.

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			20,265	20,265		20,265	54,106	74,371		30
31	Amortization of Pre-Op. & Org.										31
32	Interest							54,091	54,091		32
33	Real Estate Taxes					17,906	17,906	162,004	179,910		33
34	Rent-Facility & Grounds			360,000	360,000		360,000	(360,000)			34
35	Rent-Equipment & Vehicles			5,876	5,876		5,876	5,404	11,280		35
36	Other (specify):*							6,933	6,933		36
37	TOTAL Ownership			386,141	386,141	17,906	404,047	(77,462)	326,585		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		23,034	102,632	125,666		125,666		125,666		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			108,217	108,217		108,217		108,217		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		23,034	210,849	233,883		233,883		233,883		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,487,496	225,968	1,372,394	3,085,858		3,085,858	(294,764)	2,791,094		45

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

Park Ridge Care Center

ID# 0039255

Report Period Beginning: 01/01/17

Ending: 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Sequestration Expense	\$ (9,519)	21	1
2	Bank Charges	(3,223)	21	2
3	Prior Period Office Expenses	(140,474)	21	3
4	Prior Period - Medical Expense	(332)	10	4
5	Prior Period - Maintenance Expense	(68)	06	5
6	Prior Period - Professional Fees	(150)	19	6
7	Prior Period - Benefits	(925)	22	7
8	Bldg Co - Office Expenses	(175)	21	8
9	Bldg Co - Accounting Expenses	(14,141)	19	9
10	Bldg Co - Miscellaneous Expenses	(2,014)	21	10
11	Additional R&M	(7,849)	06	11
12	PAC Dues	(3,404)	20	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(182,273)		49

Park Ridge Care Center

ID# 0039255
 Report Period Beginning: 01/01/17
 Ending: 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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	Total		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park Ridge Care Center# 0039255

Report Period Beginning:

01/01/17

Ending:

12/31/17

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	(735)		429									(306)	5
6	Maintenance	(7,917)	39,292	3,332									34,707	6
7	Other (specify):*			87									87	7
8	TOTAL General Services	(8,652)	39,292	3,848									34,488	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(332)											(332)	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	(332)											(332)	16
	C. General Administration													
17	Administrative				27,169								27,169	17
18	Directors Fees													18
19	Professional Services	(14,291)	14,141	(35,642)									(35,792)	19
20	Fees, Subscriptions & Promotions	(5,029)		1,545									(3,484)	20
21	Clerical & General Office Expenses	(301,223)	2,189	39,975	3,260								(255,799)	21
22	Employee Benefits & Payroll Taxes	(925)											(925)	22
23	Inservice Training & Education													23
24	Travel and Seminar			144									144	24
25	Other Admin. Staff Transportation			1,472									1,472	25
26	Insurance-Prop.Liab.Malpractice		2,197	1,727									3,924	26
27	Other (specify):*			6,362		5,471							11,833	27
28	TOTAL General Administration	(321,468)	18,527	15,583	30,429	5,471							(251,458)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(330,451)	57,819	19,431	30,429	5,471							(217,302)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(11,119)	64,020	1,205									54,106	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(3,294)	56,647	738									54,091	32
33	Real Estate Taxes		160,663	1,341									162,004	33
34	Rent-Facility & Grounds		(360,000)										(360,000)	34
35	Rent-Equipment & Vehicles			5,404									5,404	35
36	Other (specify):*		6,933										6,933	36
37	TOTAL Ownership	(14,413)	(71,737)	8,688									(77,462)	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)	(344,864)	(13,918)	28,119	30,429	5,471							(294,764)	45

Facility Name & ID Number

Park Ridge Care Center

0039255

Report Period Beginning:

01/01/17

Ending:

12/31/17

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	100.00%	\$	\$ (360,000)	1
2	V	32 Interest Income	82	665 Busse Highway Limited Partnership	100.00%		(82)	2
3	V	32 Interest Expense - Mortgage		665 Busse Highway Limited Partnership	100.00%	56,729	56,729	3
4	V	30 Depreciation		665 Busse Highway Limited Partnership	100.00%	64,020	64,020	4
5	V	36 MIP Insurance		665 Busse Highway Limited Partnership	100.00%	6,933	6,933	5
6	V	33 Real Estate Taxes		665 Busse Highway Limited Partnership	100.00%	160,663	160,663	6
7	V	06 Repairs and Maintenance		665 Busse Highway Limited Partnership	100.00%	39,292	39,292	7
8	V	26 Insurance		665 Busse Highway Limited Partnership	100.00%	2,197	2,197	8
9	V	21 Office Expenses		665 Busse Highway Limited Partnership	100.00%	175	175	9
10	V	19 Accounting		665 Busse Highway Limited Partnership	100.00%	14,141	14,141	10
11	V	21 Other Expenses		665 Busse Highway Limited Partnership	100.00%	2,014	2,014	11
12	V							12
13	V							13
14	Total		\$ 360,082			\$ 346,164	\$ * (13,918)	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%	\$ 429	\$	429	15
16	V	6 REPAIRS & MAINT. - SALARIES		DYNAMIC HEALTH CARE CONS.	100.00%	1,301		1,301	16
17	V	6 REPAIRS & MAINT. - OTHER EXPENSE		DYNAMIC HEALTH CARE CONS.	100.00%	2,031		2,031	17
18	V	7 EMP. BEN-GEN SERV.		DYNAMIC HEALTH CARE CONS.	100.00%	87		87	18
19	V	19 PROFESSIONAL FEES		DYNAMIC HEALTH CARE CONS.	100.00%	250		250	19
20	V	20 DUES AND SUBSCRIPTIONS		DYNAMIC HEALTH CARE CONS.	100.00%	1,545		1,545	20
21	V	21 CLERICAL & GENERAL - SALARIES		DYNAMIC HEALTH CARE CONS.	100.00%	28,515		28,515	21
22	V	21 CLERICAL & GENERAL - OTHER EXPENSE		DYNAMIC HEALTH CARE CONS.	100.00%	11,460		11,460	22
23	V	24 SEMINARS AND TRAVEL		DYNAMIC HEALTH CARE CONS.	100.00%	144		144	23
24	V	25 AUTO EXP.		DYNAMIC HEALTH CARE CONS.	100.00%	1,472		1,472	24
25	V	26 INSURANCE		DYNAMIC HEALTH CARE CONS.	100.00%	1,727		1,727	25
26	V	27 EMP.BEN. - GEN. ADMIN.		DYNAMIC HEALTH CARE CONS.	100.00%	6,362		6,362	26
27	V	30 DEPRECIATION		DYNAMIC HEALTH CARE CONS.	100.00%	1,205		1,205	27
28	V	32 INTEREST		DYNAMIC HEALTH CARE CONS.	100.00%	738		738	28
29	V	33 REAL ESTATE TAXES		DYNAMIC HEALTH CARE CONS.	100.00%	1,341		1,341	29
30	V	19 REAL ESTATE TAX PROTEST FEES		DYNAMIC HEALTH CARE CONS.	100.00%	108		108	30
31	V	35 AUTO RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	5,182		5,182	31
32	V	35 EQUIPMENT RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	222		222	32
33	V								33
34	V	19 HOME OFFICE	36,000	DYNAMIC HEALTH CARE CONS.	100.00%			(36,000)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 36,000			\$ 64,119	\$ *	28,119	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%	8,329	8,329	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%	3,272	3,272	19
20	V	17 ADMIN. CMP. - S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%			20
21	V	17 ADMIN. CMP. - R. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			21
22	V	17 ADMIN. CMP. - S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%			22
23	V	17 ADMIN. CMP. - D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%			23
24	V	17 ADMIN. CMP. - H. ALTER		DYNAMIC HEALTH CARE CONS.	100.00%			24
25	V	17 ADMIN. CMP. - V. DAVIS (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	5,572	5,572	25
26	V	17 ADMIN. CMP. - VAR. (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%			26
27	V	17 ADMIN. CMP. - CFO (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	9,996	9,996	27
28	V	21 CLERICAL CMP. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	3,239	3,239	28
29	V	21 CLERICAL CMP. - E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	21	21	29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 30,429	\$ * 30,429	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%	1,568	1,568	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%	331	331	19
20	V	27 EMP. BEN.- S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%			20
21	V	27 EMP. BEN.- R. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			21
22	V	27 EMP. BEN.- S. HARAMARAS		DYNAMIC HEALTH CARE CONS.	100.00%			22
23	V	27 EMP. BEN.- D. KUFTA		DYNAMIC HEALTH CARE CONS.	100.00%			23
24	V	27 EMP. BEN.- H. ALTER		DYNAMIC HEALTH CARE CONS.	100.00%			24
25	V	27 EMP. BEN.-V. DAVIS (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	1,495	1,495	25
26	V	27 EMP. BEN.- NON-OWNER		DYNAMIC HEALTH CARE CONS.	100.00%			26
27	V	27 EMP. BEN.- CFO (NON-OWNER)		DYNAMIC HEALTH CARE CONS.	100.00%	1,155	1,155	27
28	V	27 EMP. BEN.- S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	774	774	28
29	V	27 EMP. BEN.- E. MARYLES		DYNAMIC HEALTH CARE CONS.	100.00%	148	148	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		\$			\$ 5,471	\$ * 5,471	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		\$			\$	\$	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: 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:	
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.

Facility Name & ID Number

Park Ridge Care Center

0039255

Report Period Beginning:

01/01/17

Ending:

12/31/17

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	1.67	3.33%	Alloc Salary	\$ 8,329	17-07	1	
2	Esther Maryles	Relative	Administrative	0%	See Attached	0.12	0.42%	Alloc Salary	21	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	\$ 8,350		13	

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

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

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/17

Ending: 12/31/17

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:

01/01/17

Ending: 12/31/17

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	371,884	11	\$ 10,844	\$ 14,712	\$ 429	1	
2	6	REPAIRS & MAINT. - SALARIE	PATIENT DAYS	371,884	11	32,891	32,891	14,712	1,301	2
3	6	REPAIRS & MAINT. - OTHER E	PATIENT DAYS	371,884	11	51,340		14,712	2,031	3
4	7	EMP. BEN-GEN SERV.	PATIENT DAYS	371,884	11	2,209		14,712	87	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	371,884	11	6,316		14,712	250	5
6	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	371,884	11	39,064		14,712	1,545	6
7	21	CLERICAL & GENERAL - SAL	PATIENT DAYS	371,884	11	720,780	720,780	14,712	28,515	7
8	21	CLERICAL & GENERAL - OTH	PATIENT DAYS	371,884	11	289,675		14,712	11,460	8
9	24	SEMINARS AND TRAVEL	PATIENT DAYS	371,884	11	3,633		14,712	144	9
10	25	AUTO EXP.	PATIENT DAYS	371,884	11	37,201		14,712	1,472	10
11	26	INSURANCE	PATIENT DAYS	371,884	11	43,644		14,712	1,727	11
12	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	371,884	11	160,819		14,712	6,362	12
13	30	DEPRECIATION	PATIENT DAYS	371,884	11	30,466		14,712	1,205	13
14	32	INTEREST	PATIENT DAYS	371,884	11	18,656		14,712	738	14
15	33	REAL ESTATE TAXES	PATIENT DAYS	371,884	11	33,889		14,712	1,341	15
16	19	REAL ESTATE TAX PROTEST	PATIENT DAYS	371,884	11	2,725		14,712	108	16
17	35	AUTO RENTAL	PATIENT DAYS	371,884	11	130,997		14,712	5,182	17
18	35	EQUIPMENT RENTAL	PATIENT DAYS	371,884	11	5,607		14,712	222	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,620,756	\$ 753,671	\$ 64,119		25

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/17

Ending: 12/31/17

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	7	58,337	58,337	-	1
2	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	11	200,000	200,000	1.67	8,329
3	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	7	200,000	200,000	-	3
4	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	5	2,500	2,500	-	4
5	17	ADMIN. CMP. - D. AARON	WGHTD. AVG. HOURS	40	11	76,541	76,541	1.71	3,272
6	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	101,000	101,000	-	6
7	17	ADMIN. CMP. - R. AARON	WGHTD. AVG. HOURS	40	1	61,541	61,541	-	7
8	17	ADMIN. CMP. - S. HARAMARA	WGHTD. AVG. HOURS	30	3	71,909	71,909	-	8
9	17	ADMIN. CMP. - D. KUFTA	WGHTD. AVG. HOURS	40	7	147,753	147,753	-	9
10	17	ADMIN. CMP. - H. ALTER	WGHTD. AVG. HOURS	40	1	12,000	12,000	-	10
11	17	ADMIN. CMP. - V. DAVIS (NON-	WGHTD. AVG. HOURS	40	9	133,816	133,816	1.67	5,572
12	17	ADMIN. CMP. - VAR. (NON-OW	WGHTD. AVG. HOURS	45	7	252,333	252,333	-	12
13	17	ADMIN. CMP. - CFO (NON-OW)	WGHTD. AVG. HOURS	40	9	240,048	240,048	1.67	9,996
14	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	9	77,614	77,614	1.67	3,239
15	21	CLERICAL CMP. - E. MARYLE	WGHTD. AVG. HOURS	28	11	5,000	5,000	0.12	21
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,640,392	\$ 1,640,392	\$	30,429

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	7	6,305	-		1
2	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	11	37,655	1.67	1,568	2
3	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	7	41,575	-		3
4	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	5	42,544	-		4
5	27	EMP. BEN.- D. AARON	WGHTD. AVG. HOURS	40	11	7,737	1.71	331	5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	37,621	-		6
7	27	EMP. BEN.- R. AARON	WGHTD. AVG. HOURS	40	1	27,046	-		7
8	27	EMP. BEN.- S. HARAMARAS	WGHTD. AVG. HOURS	30	3	28,711	-		8
9	27	EMP. BEN.- D. KUFTA	WGHTD. AVG. HOURS	40	7	11,492	-		9
10	27	EMP. BEN.- H. ALTER	WGHTD. AVG. HOURS	40	1	1,095	-		10
11	27	EMP. BEN.-V. DAVIS (NON-OW	WGHTD. AVG. HOURS	40	9	35,890	1.67	1,495	11
12	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	7	68,533	-		12
13	27	EMP. BEN.- CFO (NON-OWNER	WGHTD. AVG. HOURS	40	9	27,736	1.67	1,155	13
14	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	9	18,548	1.67	774	14
15	27	EMP. BEN. - E. MARYLES	WGHTD. AVG. HOURS	28	11	35,535	0.12	148	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 428,023	\$	\$ 5,471	25

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/17

Ending: 12/31/17

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:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____) _____

Fax Number (_____) _____

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.

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:

01/01/17

Ending: 12/31/17

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:

01/01/17

Ending: 12/31/17

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: **01/01/17** Ending: **12/31/17**

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:

01/01/17

Ending: 12/31/17

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:

01/01/17

Ending:

12/31/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Midland		X	Mortgage			\$	\$ 1,247,660		\$ 56,729	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6											6									
7											7									
8											8									
9	TOTAL Facility Related						\$	\$ 1,247,660		\$ 56,729	9									
B. Non-Facility Related*																				
10	Interest Income		X							(3,294)	10									
11	Interest Income - Bldg Co.		X							(82)	11									
12	Allocated from Dynamic Healthcare									738	12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$ (2,638)	14									
15	TOTALS (line 9+line14)						\$	\$ 1,247,660		\$ 54,091	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 6,933 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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park Ridge Care Center COUNTY Cook
 FACILITY IDPH LICENSE NUMBER 0039255
 CONTACT PERSON REGARDING THIS REPORT Steve Lavenda
 TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(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.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

Facility Name & ID Number Park Ridge Care Center

0039255 Report Period Beginning:

01/01/17 Ending:

12/31/17

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

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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and an unlabeled column. Row 1: Facility, \$49,000, 1. Row 2: (blank), 2. Row 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	\$ 64,020	39	\$ 33,923	\$ (30,097)	\$ 815,566	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1994	8,310		20			8,310	9
10	Various		1995	33,691		20			33,691	10
11	Various		1997	21,547		20	540	540	20,763	11
12	Various		1998	18,893		20	945	945	18,174	12
13	Various		1999	7,527		20	376	376	6,953	13
14	Various		2000	68,323		20	3,376	3,376	59,140	14
15	Various		2001	3,525		20	81	81	3,220	15
16	Various		2002	5,638		20	185	185	4,806	16
17	Various		2003	24,130		20	350	350	22,151	17
18	Various		2004	3,490		20	175	175	2,347	18
19	Various		2005	1,858		20	93	93	1,156	19
20	Various		2006	6,500		20	325	325	3,658	20
21	Various		2008	11,545		20	573	573	8,562	21
22	Various		2010	6,813		20	273	273	2,057	22
23	Various		2011	11,965		20	307	307	1,926	23
24	Various		2012	25,060		20	643	643	3,678	24
25	Various		2013	5,920		20	152	152	740	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:

01/01/17

Ending:

12/31/17

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		380,855			19,308	19,308	112,648	67
68		17,549	450		501	51	12,201	68
69			20,265			(20,265)		69
70		\$ 1,986,140	\$ 84,735		\$ 62,125	\$ (22,610)	\$ 1,141,747	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,986,140	\$ 84,735		\$ 62,125	\$ (22,610)	\$ 1,141,747	1
2	Security Cameras	2014	2,580		20	369	369	1,321	2
3	Remodeling Supplies - Window Installation	2014	2,760		20	552	552	1,840	3
4	Tuckpointing/Painting	2014	5,000		20	1,000	1,000	3,333	4
5	Install Fire Prevention Device	2015	4,300		20	123	123	338	5
6	Repair Leaking Pipes Above Corridor Ceiling	2016	2,988		20	149	149	274	6
7	Blinds For Resident Rooms	2017	3,300		20	31	31	31	7
8	New Piping And Sod-Exterior	2017	4,392		20	10	10	10	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)		\$ 2,011,460	\$ 84,735		\$ 64,360	\$ (20,375)	\$ 1,148,895	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		\$ 2,011,460	\$ 84,735		\$ 64,360	\$ (20,375)	\$ 1,148,895	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)	\$ 2,011,460	\$ 84,735		\$ 64,360	\$ (20,375)	\$ 1,148,895	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		\$ 2,011,460	\$ 84,735		\$ 64,360	\$ (20,375)	\$ 1,148,895	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		\$ 2,011,460	\$ 84,735		\$ 64,360	\$ (20,375)	\$ 1,148,895	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		\$ 2,011,460	\$ 84,735		\$ 64,360	\$ (20,375)	\$ 1,148,895	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		\$ 2,011,460	\$ 84,735		\$ 64,360	\$ (20,375)	\$ 1,148,895	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:

01/01/17

Ending:

12/31/17**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									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Flooring	2008	14,000		20	700	700	8,283	9
10	Nursing Station	2008	5,000		20	250	250	2,917	10
11	Nursing Station	2008	4,700		20	235	235	2,742	11
12	Econocare Call Light System	2008	12,011		20	601	601	7,410	12
13	Jacks & Son Asphalt Parking Lot	2008	16,033		20	802	802	9,088	13
14	Flooring	2008	14,000		20	779	779	8,569	14
15	Drop Ceiling & Lighting	2009	19,000		20	950	950	10,133	15
16	Roof Rubber Installation	2009	3,000		20	150	150	1,525	16
17	Lobby - Wallpaper, Vinyl Tile, Millwork, Cove Base	2010	4,185		20	209	209	1,672	17
18	Conference Room - Wallpaper, Vinyl Tile, Millwork, Cove Base	2010	3,909		20	195	195	1,560	18
19	Corridor - Wallpaper, Vinyl Tile, Millwork, Cove Base	2010	19,821		20	991	991	7,928	19
20	Various Areas: Wallcovering, Vinyl Flr, Paint (Drs, Drframes, & V	2010	48,069		20	2,403	2,403	19,225	20
21	Door	2011	11,077		20	554	554	3,878	21
22	Double Entry Kitchen Door	2011	3,450		20	173	173	1,211	22
23	Built-In Cabinet and Countertop	2011	6,775		20	339	339	2,373	23
24	Remodeling of 2 Bathrooms	2013	19,965		20	998	998	3,992	24
25	Roof Replacement	2013	14,300		20	715	715	2,860	25
26	Remove/Replace floor tile with Ceramic Tile in Kitchen	2015	5,875		20	294	294	882	26
27	Kitchen Hood	2015	14,500		20	725	725	2,175	27
28	Remove/Replace Basement Walls	2015	11,875		20	594	594	1,782	28
29	Kitchen Floor Tile, Replace Pipes, Countertop	2015	32,681		20	1,634	1,634	4,902	29
30	Patio and Sidewalk Concrete Work	2015	5,500		20	275	275	550	30
31	Roof Repairs	2016	22,900		20	1,145	1,145	2,290	31
32	Window Replacement	2016	14,869		20	929	929	1,858	32
33	Gutters and Downspouts	2016	3,495		20	175	175	350	33
34	TOTAL (lines 1 thru 33)		\$ 330,990	\$		\$ 16,815	\$ 16,815	\$ 110,155	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 330,990	\$		\$ 16,815	\$	\$ 110,155	1
2	Tuckpoint, Sidewalk Replacement, paint- front porch, entrance								2
3	laundry rm, kitchen, rsdnt bathroom, new ramp handrail	2017	42,880		20	2,144	2,144	2,144	3
4	Replace Metal Door in Basement, install electrical panel door locks	2017	2,768		20	138	138	138	4
5	Window Repair in Basement - Thermal Treatment	2017	4,217		20	211	211	211	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)		\$ 380,855	\$		\$ 19,308	\$ 2,493	\$ 112,648	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	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 Healthcare Consultants	1993	17,549	450	35	501	51	12,201	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)		\$ 17,549	\$ 450		\$ 501	\$ 51	\$ 12,201	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		\$ 17,549	\$ 450		\$ 501	\$ 51	\$ 12,201	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)	\$ 17,549	\$ 450		\$ 501	\$ 51	\$ 12,201	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	\$ 55,547	\$ 156	\$ 7,233	\$ 7,077	10	\$ 43,294	71
72	Current Year Purchases	14,104		2,272	2,272	10	2,272	72
73	Fully Depreciated Assets	283,192		13	13	10	283,153	73
74								74
75	TOTALS	\$ 352,843	\$ 156	\$ 9,518	\$ 9,362		\$ 328,719	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Dynamic Healthcare		\$ 11,711	\$ 599	\$ 493	\$ (106)	5	\$ 9,324	76
77										77
78										78
79										79
80	TOTALS			\$ 11,711	\$ 599	\$ 493	\$ (106)		\$ 9,324	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)	\$ 2,425,014	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 85,490	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 74,371	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (11,119)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,486,939	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?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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: \$ 3,272 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	\$ 2,826	17
18	Allocated from Dynamic Healthcare			5,182	18
19					19
20					20
21	TOTAL		\$ 525	\$ 8,008	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>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			
		1	2	3	4
		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		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					\$ 48,025							\$ 48,025	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					2,004							2,004	2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39 - 03	hrs					50,994							50,994	4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy	39 - 02	# of prescrpts							22,677					22,677	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): _____															12
13	Other (specify): _____							1,609		357					1,966	13
14	TOTAL				\$			\$ 102,632		\$ 23,034				\$	125,666	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# 0039255Report Period Beginning: 01/01/17Ending: 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/17

(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	\$ 405,736	\$ 503,209	1
2	Cash-Patient Deposits	57,417	57,417	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	449,841	449,841	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	49,519	55,737	6
7	Other Prepaid Expenses	5,071	5,071	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	17,650	309,309	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 985,234	\$ 1,380,584	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		49,000	13
14	Buildings, at Historical Cost		1,323,000	14
15	Leasehold Improvements, at Historical Cost	405,471	677,786	15
16	Equipment, at Historical Cost	199,223	396,113	16
17	Accumulated Depreciation (book methods)	(432,197)	(1,589,065)	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): <u>See Attached Schedule</u>	9,348	51,503	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 181,845	\$ 908,337	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,167,079	\$ 2,288,921	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 162,559	\$ 162,559	26
27	Officer's Accounts Payable	32,500	32,500	27
28	Accounts Payable-Patient Deposits	57,417	57,417	28
29	Short-Term Notes Payable		29,397	29
30	Accrued Salaries Payable	153,814	153,814	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,233	5,233	31
32	Accrued Real Estate Taxes(Sch.IX-B)		180,000	32
33	Accrued Interest Payable		4,679	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	20,506	20,506	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 432,029	\$ 646,105	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,218,263	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)	\$	\$ 1,218,263	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 432,029	\$ 1,864,368	46
47	TOTAL EQUITY(page 18, line 24)	\$ 735,050	\$ 424,553	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,167,079	\$ 2,288,921	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,286,838	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,286,838	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	8,212	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	(560,000)	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)	\$ (551,788)	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)	\$ 735,050	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning: 01/01/17

Ending:

12/31/17

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	\$ 3,012,553	1
2	Discounts and Allowances for all Levels	(342,107)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,670,446	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	337,230	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 337,230	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	24,048	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,615	19
20	Radiology and X-Ray	500	20
21	Other Medical Services	437	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 28,600	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,294	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,294	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	54,500	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 54,500	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,094,070	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	514,162	31
32	Health Care	1,113,072	32
33	General Administration	838,600	33
B. Capital Expense			
34	Ownership	386,141	34
C. Ancillary Expense			
35	Special Cost Centers	125,666	35
36	Provider Participation Fee	108,217	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,085,858	40
41	Income before Income Taxes (line 30 minus line 40)**	8,212	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 8,212	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 2,140,940	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue	525,056	46
47	Other-(specify) <u>Hospice/Insurance/Ancillary Contractual Allow.</u>	4,450	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,670,446	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:

01/01/17

Ending:

12/31/17

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	4,435	4,709	\$ 196,722	\$ 41.78	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,068	7,584	241,868	31.89	3
4	Licensed Practical Nurses	1,610	1,619	39,044	24.12	4
5	CNAs & Orderlies	32,153	34,368	480,811	13.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,994	2,126	44,833	21.09	9
10	Activity Assistants	1,878	1,915	21,812	11.39	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,345	2,606	59,489	22.83	13
14	Head Cook	3,787	4,057	63,251	15.59	14
15	Cook Helpers/Assistants	3,834	3,971	45,743	11.52	15
16	Dishwashers					16
17	Maintenance Workers	1,933	2,103	46,395	22.06	17
18	Housekeepers	5,289	5,676	65,673	11.57	18
19	Laundry	3,765	3,912	45,065	11.52	19
20	Administrator	2,026	2,382	131,520	55.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					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	417	528	5,270	9.98	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	72,534	77,556	\$ 1,487,496 *	\$ 19.18	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	24	\$ 600	01-03	35
36	Medical Director	96	6,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	48	3,066	10-03	38
39	Pharmacist Consultant	per bed	3,857	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	13	689	11-03	44
45	Social Service Consultant	22	1,430	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	203	\$ 15,642		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

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 - \$6,808
- (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. \$ 25,788 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. \$ 108,217
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. \$ 529 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