

		FOR BHF USE					

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

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

I. IDPH License ID Number: 0045815

Facility Name: Chicago Ridge Nursing Center

Address: 10602 Southwest Hwy Chicago Ridge 60415
Number City Zip Code

County: Cook

Telephone Number: 773-252-3208 Fax # 773-252-3688

HFS ID Number:

Date of Initial License for Current Owners: 11/01/2001

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Mendel Schneider Telephone Number: 847-933-1274
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2020 to 12/31/220 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) _____
(Title) _____

Paid
Preparer

(Signed) See Accountant's Report Attached (Date) _____
(Print Name and Title) _____
(Firm Name & Address) Mendel S Schneider & Associates CPA PC
4051 Old Orchard rd Skokie Illinois 60076
(Telephone) 847-933-1274 Fax # 847-933-1283

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Chicago Ridge Nursing Center

0045815 Report Period Beginning: 01/01/2020 Ending: 12/31/220

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>231</u>	Skilled (SNF)	<u>231</u>	<u>84,546</u>	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	<u>231</u>	TOTALS	<u>231</u>	<u>84,546</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>60,774</u>	<u>1,668</u>	<u>6,356</u>	<u>68,798</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>60,774</u>	<u>1,668</u>	<u>6,356</u>	<u>68,798</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.37%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

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

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

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 11/01/2001

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 11/01/2001 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 38 and days of care provided 2,542

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31 Fiscal Year: 12/31
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2020 Ending: 12/31/220
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	446,457	11,174	9,734	467,365		467,365		467,365			1
2	Food Purchase		399,921		399,921		399,921	(337)	399,584			2
3	Housekeeping	485,038	33,264		518,302		518,302		518,302			3
4	Laundry	125,373	8,096		133,469		133,469		133,469			4
5	Heat and Other Utilities			224,632	224,632		224,632	2,604	227,236			5
6	Maintenance	40,633	26,306	56,081	123,020		123,020	111,542	234,562			6
7	Other (specify):*											7
8	TOTAL General Services	1,097,501	478,761	290,447	1,866,709		1,866,709	113,809	1,980,518			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	3,164,501	255,462	559,276	3,979,239		3,979,239		3,979,239			10
10a	Therapy											10a
11	Activities	151,924	3,071		154,995		154,995		154,995			11
12	Social Services	165,100			165,100		165,100		165,100			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,481,525	258,533	559,276	4,299,334		4,299,334		4,299,334			16
	C. General Administration											
17	Administrative			1,249,470	1,249,470		1,249,470	(1,051,220)	198,250			17
18	Directors Fees											18
19	Professional Services			100,686	100,686		100,686	23,066	123,752			19
20	Dues, Fees, Subscriptions & Promotions			32,816	32,816		32,816	(6,725)	26,091			20
21	Clerical & General Office Expenses	327,667	19,928	163,946	511,541		511,541	180,547	692,088			21
22	Employee Benefits & Payroll Taxes			683,421	683,421		683,421	36,848	720,269			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			389,090	389,090		389,090	497,589	886,679			26
27	Other (specify):*											27
28	TOTAL General Administration	327,667	19,928	2,619,429	2,967,024		2,967,024	(319,895)	2,647,129			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,906,693	757,222	3,469,152	9,133,067		9,133,067	(206,086)	8,926,981			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			29,517	29,517		29,517	288,453	317,970			30
31	Amortization of Pre-Op. & Org.							3,565	3,565			31
32	Interest							348,937	348,937			32
33	Real Estate Taxes							663,388	663,388			33
34	Rent-Facility & Grounds			2,168,342	2,168,342		2,168,342	(2,168,342)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Bad Debt			46,353	46,353		46,353	(46,353)				36
37	TOTAL Ownership			2,244,212	2,244,212		2,244,212	(910,352)	1,333,860			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			409,112	409,112		409,112		409,112			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			529,037	529,037		529,037		529,037			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			938,149	938,149		938,149		938,149			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	4,906,693	757,222	6,651,513	12,315,428		12,315,428	(1,116,438)	11,198,990			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(103,552)	30		9
10	Interest and Other Investment Income	(46,114)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(337)	2		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	(34,308)	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	(46,353)	36		24
25	Fund Raising, Advertising and Promotional	(6,725)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(11,316)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (248,705)		\$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(867,733)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (867,733)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,116,438)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Chicago Ridge Nursing Center# 0045815

Report Period Beginning:

01/01/2020

Ending:

12/31/220

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(337)	0	0	0	0	0	0	0	0	0	0	(337)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,604	0	0	0	0	0	0	0	0	2,604	5
6	Maintenance	0	0	111,542	0	0	0	0	0	0	0	0	111,542	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(337)	0	114,146	0	0	0	0	0	0	0	0	113,809	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(1,051,220)	0	0	0	0	0	0	0	0	(1,051,220)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,500	14,566	0	0	0	0	0	0	0	0	23,066	19
20	Fees, Subscriptions & Promotions	(6,725)	0	0	0	0	0	0	0	0	0	0	(6,725)	20
21	Clerical & General Office Expenses	(45,624)	126	226,045	0	0	0	0	0	0	0	0	180,547	21
22	Employee Benefits & Payroll Taxes	0	0	36,848	0	0	0	0	0	0	0	0	36,848	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	494,749	2,840	0	0	0	0	0	0	0	0	497,589	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(52,349)	503,375	(770,921)	0	0	0	0	0	0	0	0	(319,895)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(52,686)	503,375	(656,775)	0	0	0	0	0	0	0	0	(206,086)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2020 Ending: 12/31/220

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	(103,552)	392,005	0	0	0	0	0	0	0	0	0	288,453	30
31	Amortization of Pre-Op. & Org.	0	3,565	0	0	0	0	0	0	0	0	0	3,565	31
32	Interest	(46,114)	395,051	0	0	0	0	0	0	0	0	0	348,937	32
33	Real Estate Taxes	0	651,580	11,808	0	0	0	0	0	0	0	0	663,388	33
34	Rent-Facility & Grounds	0	(2,168,342)	0	0	0	0	0	0	0	0	0	(2,168,342)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(46,353)	0	0	0	0	0	0	0	0	0	0	(46,353)	36
37	TOTAL Ownership	(196,019)	(726,141)	11,808	0	0	0	0	0	0	0	0	(910,352)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(248,705)	(222,766)	(644,967)	0	0	0	0	0	0	0	0	(1,116,438)	45

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
Joseph Mermelstein	25	Winston Manor Nursing Home	Chicago	Nivram Mgmt Co	Lincolnwood	Mgmt Co
Marvin Mermelstein	50	Balmoral Nursing Home	Chicago	BM Real Estate		Bldg Rental
Barry Taerbum	25	Central Nursing Home	Chicago			
		Paul House Health Care Center	Chicago			

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	Rent	\$ 2,168,342	BM of Chicago Ridge Real Estate LLC	100.00%	\$	\$ (2,168,342)	1
2	V	30	Depreciation		BM of Chicago Ridge Real Estate LLC		392,005	392,005	2
3	V	33	Real Estate Tax		BM of Chicago Ridge Real Estate LLC		651,580	651,580	3
4	V	32	Interest		BM of Chicago Ridge Real Estate LLC		395,051	395,051	4
5	V	19	Professional Fees		BM of Chicago Ridge Real Estate LLC		8,500	8,500	5
6	V	26	Insurance		BM of Chicago Ridge Real Estate LLC		494,749	494,749	6
7	V	31	Amortization		BM of Chicago Ridge Real Estate LLC		3,565	3,565	7
8	V	21	Office		BM of Chicago Ridge Real Estate LLC		126	126	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 2,168,342			\$ 1,945,576	\$ * (222,766)	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.

☒ X

 YES

☐ NO

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

1		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	17	Management Fees	\$ 1,249,470	Nivram Management Inc	100.00%	\$	\$ (1,249,470)	15
16	V	21	Payroll		Nivram Management Inc		137,227	137,227	16
17	V	22	Payroll Taxes		Nivram Management Inc		36,848	36,848	17
18	V	33	Real Estate Tax		Nivram Management Inc		11,808	11,808	18
19	V	5	Utilities		Nivram Management Inc		2,604	2,604	19
20	V	6	Repair & Maintenance		Nivram Management Inc		1,536	1,536	20
21	V	26	Insurance		Nivram Management Inc		2,840	2,840	21
22	V	19	Professional Fees		Nivram Management Inc		14,566	14,566	22
23	V	21	Office		Nivram Management Inc		30,110	30,110	23
24	V	17	Marvin Mermelstein		Nivram Management Inc		19,807	19,807	24
25	V	21	Doreen Mermelstein		Nivram Management Inc		2,035	2,035	25
26	V	21	Jacob Mermelstein		Nivram Management Inc		30,674	30,674	26
27	V	21	Joel Mermelstein		Nivram Management Inc		25,999	25,999	27
28	V	6	Maintenance Salary		Nivram Management Inc		110,006	110,006	28
29	V	17	Administrator Salary		Nivram Management Inc		178,443	178,443	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			\$ 1,249,470			\$ 604,503	\$ * (644,967)	39

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

VII. RELATED PARTIES

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

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2020 Ending: 12/31/220

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	Marvin Mermelstein		Adm	50.00	64,139	10	20.00	Salary	\$ 19,807	17	1
2	Doreen Mermelstein		Clerical		6,588	10	20.00	Salary	2,035	21	2
3	Jacob Mermelstein		Clerical		99,326	10	20.00	Salary	30,674	21	3
4	Joel Mermelstein		Clerical		84,188	10	20.00	Salary	25,999	21	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 78,515		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 Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2020 Ending: 12/31/220

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 Nivram Mgmt Inc
Street Address 6500 N Hamlin
City / State / Zip Code Lincolnwood, IL 60712
Phone Number (847-679-7484
Fax Number (847-679-7494

	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	21	Payroll	Resident Beds	979	5	\$ 581,580	\$ 581,580	231	\$ 137,227	1
2	22	Payroll Taxes	Resident Beds	979	5	156,164		231	36,848	2
3	33	Real Estate Tax	Resident Beds	979	5	50,044		231	11,808	3
4	5	Utilities	Resident Beds	979	5	11,038		231	2,604	4
5	6	Repairs & Maintenance	Resident Beds	979	5	6,509		231	1,536	5
6	26	Insurance	Resident Beds	979	5	12,037		231	2,840	6
7	19	Professional Fees	Resident Beds	979	5	61,734		231	14,566	7
8	21	Office	Resident Beds	979	5	127,608		231	30,110	8
9	17	Marvin Mermelstein	Resident Beds	979	5	83,946	83,946	231	19,807	9
10	21	Doreen Mermelstein	Resident Beds	979	5	8,623	8,623	231	2,035	10
11	21	Jacob Mermelstein	Resident Beds	979	5	130,000	130,000	231	30,674	11
12	21	Joel Mermelstein	Resident Beds	979	5	110,187	110,187	231	25,999	12
13	6	Maintenance Salary	Resident Beds			110,006	110,006		110,006	13
14	17	Administrator Salary	Resident Beds			178,443	178,443		178,443	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,627,919	\$ 1,202,785		\$ 604,503	25

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	Berkely Point Capital		X	Mortgage	\$178,767.00	2012	\$ 13,345,000	\$ 11,137,844	05/22/47	3.4300	\$ 395,051	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				\$178,767.00		\$ 13,345,000	\$ 11,137,844			\$ 395,051	9
	B. Non-Facility Related*											
10	Interest Income		X								(46,114)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (46,114)	14
15	TOTALS (line 9+line14)						\$ 13,345,000	\$ 11,137,844			\$ 348,937	15

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

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

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Chicago Ridge Nursing Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0045815

CONTACT PERSON REGARDING THIS REPORT Robb Strukoff

TELEPHONE 847-715-2522 FAX #: 847-941-0101

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 24-18-101-025-0000	Facility	\$ 470,704.51	\$ 470,704.51
2. 24-18-101-039-0000	Facility	\$ 177,541.49	\$ 177,541.49
3.		\$	\$
4.		\$	\$
5. 10-35-325-015-0000	Allocated from Mgmt Co	\$ 42,470.18	\$ 10,021.00
6. 10-35-325-029-0000	Allocated from Mgmt Co	\$ 7,574.20	\$ 1,787.00
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 698,290.38	\$ 660,054.00

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

A. Square Feet: 87,480

B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

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).

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: 124,790

2. Number of Years Over Which it is Being Amortized: 35

3. Current Period Amortization: 3,565

4. Dates Incurred: 5/22/12

Nature of Costs: Mortgage 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	Facility	73,980	2007	\$ 435,000	1
2					2
3	TOTALS	73,980		\$ 435,000	3

Facility Name & ID Number Chicago Ridge Nursing Center

0045815

Report Period Beginning:

01/01/2020

Ending:

12/31/220

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	231		2007		\$ 9,678,293	\$ 357,798	27.5	\$ 249,034	\$ (108,764)	\$ 3,402,098	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Carpet		2002		2,240	81	27.5	81		1,472	9
10	Washer Dryer		2002		29,304		27.5			29,304	10
11	Phone System		2002		10,667	388	27.5	388		9,523	11
12	A/C System		2002		11,200	407	27.5	407		9,997	12
13	Electrical Improvements		2002		3,000	109	27.5	109		2,678	13
14	Light Fixtures		2002		10,192	371	27.5	371		9,103	14
15	Water Heater		2003		16,500		5			16,500	15
16	Bathroom Improvement		2005		634	23	27.5	23		468	16
17	Fire Smoke Dampers		2005		3,475	126	27.5	126		2,672	17
18	Boiler		2005		11,960		5			11,960	18
19	AC Chiller Unit		2006		81,000	2,937	27.5	2,937		57,277	19
20	Locks		2006		4,374	160	27.5	160		2,905	20
21	Fire Alarm System		2006		98,711	3,580	27.5	3,580		65,527	21
22	Furnace		2007		13,500	492	27.5	492		8,836	22
23	Temp reset Control for Boiler		2007		2,750	100	27.5	100		1,786	23
24	Electrical Disconnect for Chiller Unit		2007		8,000	290	27.5	290		5,194	24
25	AC Chiller Unit		2007		8,000	292	27.5	292		5,160	25
26	Hot Water Storage Unit		2007		22,000	802	27.5	802		13,976	26
27	Control System for New Chiller		2007		1,191	43	27.5	43		764	27
28	Grab Bars		2007		4,941	179	27.5	179		3,137	28
29	Boiler Change		2007		8,380	305	27.5	305		5,284	29
30	Water Cooler Attached to Bldg		2007		1,087	40	27.5	40		708	30
31	Carpeting		2007		3,138	114	27.5	114		1,901	31
32	Exhaust Fans		2009		7,098	258	27.5	258		3,654	32
33	Sprinkler System		2010		239,314	8,702	27.5	8,702		60,733	33
34	Boiler		2010		47,900	1,742	27.5	1,742		11,838	34
35	Electrical Breakers		2010		7,000	254	27.5	254		1,775	35
36	Fire Alarm		2011		8,982	324	27.5	324		2,577	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 Chicago Ridge Nursing Center

0045815

Report Period Beginning:

01/01/2020 Ending: 12/31/220

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	
37	Therapy Room-Flooring, Cabinets, Countertops	2011	\$ 2,635	\$ 96	27.5	\$ 96		\$ 1,050	37
38	Water Heater	2011	8,170		10	817	817	8,170	38
39	Sprinkler System	2011	4,000	146	27.5	146		1,090	39
40	Sprinkler System	2012	6,370	224	27.5	224		1,648	40
41	Laminate Flooring	2012	4,768	174	27.5	174		1,605	41
42	Stairway Exit Doors	2012	9,097	331	27.5	331		2,677	42
43	Water Pump	2013	2,625	96	27.5	96		773	43
44	Power Conditioner	2013	5,600	204	27.5	204		1,341	44
45	Elevator	2013	147,995	5,382	27.5	5,382		35,095	45
46	Roof Replacement	2013	152,325	5,539	27.5	5,539		34,840	46
47	Parking Lot Repavement	2013	7,100	258	27.5	258		1,610	47
48	Smoking Shelter	2013	4,053	147	27.5	147		908	48
49	Wiring Upgrade	2014	6,378	232	27.5	232		1,546	49
50	Water Pump	2014	4,100	149	27.5	149		795	50
51	Water Heater	2014	8,373	401	27.5	401		2,480	51
52	Wiring and Hardware Installation for Cameras	2015	5,000	181	27.5	181		938	52
53	Corner Guards,Door Coverings,Resurfacing Panels	2015	119,999	4,364	27.5	4,364		23,456	53
54	& Installation of Nursing Station								54
55	1-3 Floor Nursing Stations/2nd Floor Hallways/Lunch Room	2016	47,000	1,709	27.5	1,709		7,619	55
56	New Generator	2016	12,250	445	27.5	445		1,335	56
57	Main Sewer-Section Replacement	2016	5,247	191	27.5	191		573	57
58	Flooring-1st Floor Hallways,Lunch Room,Elevators	2016	29,000	1,083	27.5	1,083		4,456	58
59	Flooring-Smoke Room	2016	6,100	222	27.5	222		666	59
60	2nd Floor Loft Elevators & Cove Bases	2017	33,650	1,224	27.5	1,224		4,896	60
61	Hot Water Valve	2017	5,800	211	27.5	211		844	61
62	Sewer Pipe Work	2018	5,135	189	27.5	189		565	62
63	Harrison Mechanical	2019	16,000	582	27.5	582		1,140	63
64	Contech MSI	2019	7,141	260	27.5	260		487	64
65	Carpeting	2019	69,996	2,545	27.5	2,545		4,348	65
66	Paving	2019	69,615	3,232	27.5	3,232		4,603	66
67	Surbaban Elevator	2019	15,940	580	27.5	580		701	67
68	Northshore	2019	6,500	236	27.5	236		266	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 11,172,793	\$ 410,550		\$ 302,603	\$ (107,947)	\$ 3,901,328	70

**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	\$107,568	\$10,972	\$15,367	\$4,395	7	\$89,109	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	165,799					165,799	73
74								74
75	TOTALS	\$273,367	\$10,972	\$15,367	\$4,395		\$254,908	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$11,881,160	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$421,522	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$317,970	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(103,552)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$4,156,236	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

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: \$ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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.	/2021	\$
13.	/2022	\$
14.	/2023	\$

* 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.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training CNAs from other facilities.

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			318,015			318,015	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts			91,097			91,097	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
			hrs							
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$ 409,112	\$		\$ 409,112	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.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 4,675,610	\$ 4,770,596	1
2	Cash-Patient Deposits	112,540	112,540	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,161,323	1,161,323	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,668	27,668	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	54,298	54,298	8
9	Other(specify): <u>Escrows</u>		1,804,845	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,031,439	\$ 7,931,270	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		718,076	13
14	Buildings, at Historical Cost		10,292,695	14
15	Leasehold Improvements, at Historical Cost	562,383	562,383	15
16	Equipment, at Historical Cost	307,863	2,141,297	16
17	Accumulated Depreciation (book methods)	(491,563)	(6,027,171)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 378,683	\$ 7,687,280	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,410,122	\$ 15,618,550	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 541,612	\$ 541,612	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	122,764	122,764	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	45,387	45,387	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,287	4,287	31
32	Accrued Real Estate Taxes(Sch.IX-B)		661,211	32
33	Accrued Interest Payable		33,321	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Mgmt Fees</u>	6,768,550	6,768,550	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,482,600	\$ 8,177,132	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,137,844	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)	\$	\$ 11,137,844	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,482,600	\$ 19,314,976	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,072,478)	\$ (3,696,426)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,410,122	\$ 15,618,550	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,266,491)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,266,491)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,844,013	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	(650,000)	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)	\$ 3,194,013	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)	\$ (1,072,478)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Chicago Ridge Nursing Center

0045815

Report Period Beginning: 01/01/2020

Ending: 12/31/220

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 13,367,256	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,367,256	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	45,774	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 45,774	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Stimulus Income	1,730,456	28
28a	PPP Forgiveness Income	1,015,955	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,746,411	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,159,441	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,866,709	31
32	Health Care	4,299,334	32
33	General Administration	2,967,024	33
	B. Capital Expense		
34	Ownership	2,244,212	34
	C. Ancillary Expense		
35	Special Cost Centers	409,112	35
36	Provider Participation Fee	529,037	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,315,428	40
41	Income before Income Taxes (line 30 minus line 40)**	3,844,013	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 3,844,013	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 10,178,836	44
45	Private Pay - Net Inpatient Revenue	328,910	45
46	Medicare - Net Inpatient Revenue	2,138,405	46
47	Other-(specify) <u>Veterans</u>	721,105	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 13,367,256	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No, Cash Bas 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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,544	2,781	\$ 130,509	\$ 46.93	1
2	Assistant Director of Nursing					2
3	Registered Nurses	36,412	38,220	1,405,431	36.77	3
4	Licensed Practical Nurses	12,208	13,636	403,992	29.63	4
5	CNAs & Orderlies	54,467	58,250	1,034,937	17.77	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,767	4,142	116,538	28.14	8
9	Activity Director	1,864	2,040	37,984	18.62	9
10	Activity Assistants	7,936	8,685	113,940	13.12	10
11	Social Service Workers	7,658	8,287	165,100	19.92	11
12	Dietician	1,947	2,023	47,256	23.36	12
13	Food Service Supervisor	1,696	1,818	41,572	22.87	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,168	30,284	357,629	11.81	15
16	Dishwashers					16
17	Maintenance Workers	2,039	2,759	40,633	14.73	17
18	Housekeepers	36,886	39,357	485,038	12.32	18
19	Laundry	9,166	10,040	125,373	12.49	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,346	7,823	153,696	19.65	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	4,364	4,659	173,971	37.34	31
32	Other Health Care(specify)					32
33	Other(specify) Restorative Nurses	1,935	2,068	73,094	35.35	33
34	TOTAL (lines 1 - 33)	216,403	236,872	\$ 4,906,693 *	\$ 20.71	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 9,734	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 9,734		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	4,210	\$ 252,538	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	10,220	306,738	10-3	52
53	TOTAL (lines 50 - 52)	14,430	\$ 559,276		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? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 20,000 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. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 529,037
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation. _____
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? _____
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? _____
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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. N/A
Attach invoices and a summary of services for all architect and appraisal fees.