

		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: <u>0052431</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Norridge Gardens</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2020</u> to <u>12/31/2020</u> 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.																							
Address: <u>7001 West Cullom</u> <u>Norridge</u> <u>60706</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(708) 457-0700</u> Fax # <u>(708) 457-8852</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Larry Templin Partner</u></td></tr><tr><td>(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 326, Plainfield, IL 60544-0326</u></td></tr><tr><td>(Telephone) <u>(630) 361-2868</u> Fax # ()</td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	Paid Preparer	(Print Name and Title) <u>Larry Templin Partner</u>	(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 326, Plainfield, IL 60544-0326</u>	(Telephone) <u>(630) 361-2868</u> Fax # ()	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												
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Date of Initial License for Current Owners: <u>8/1/2014</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☒ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☒ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>Larry Templin</u> Telephone Number: <u>(630) 361-2868</u>																									
Email Address: _____																									
SEE ACCOUNTANTS' PREPARATION REPORT																									

Facility Name & ID Number Norridge Gardens

0052431 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

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	<u>292</u>	Skilled (SNF)	<u>292</u>	<u>106,872</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>292</u>	TOTALS	<u>292</u>	<u>106,872</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>14,163</u>	<u>14,163</u>	8
9	SNF/PED					9
10	ICF	<u>55,887</u>	<u>5,670</u>		<u>61,557</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>55,887</u>	<u>5,670</u>	<u>14,163</u>	<u>75,720</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.85%

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 ☒ Non-allowable costs have been eliminated in Schedule V, Column 7

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 292 and days of care provided 10,649

Medicare Intermediary CGS Administrators, LLC

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20
* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/2020 Ending: 12/31/2020
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 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	761,232	61,841	92,270	915,343		915,343		915,343			1
2	Food Purchase		525,814		525,814		525,814		525,814			2
3	Housekeeping	537,272	92,581	128,204	758,057		758,057		758,057			3
4	Laundry		30,954		30,954		30,954		30,954			4
5	Heat and Other Utilities			237,664	237,664		237,664	2,335	239,999			5
6	Maintenance	134,487		134,004	268,491		268,491	2,861	271,352			6
7	Other (specify):* Waste Removal			50,779	50,779		50,779		50,779			7
8	TOTAL General Services	1,432,991	711,190	642,921	2,787,102		2,787,102	5,196	2,792,298			8
	B. Health Care and Programs											
9	Medical Director			35,000	35,000		35,000		35,000			9
10	Nursing and Medical Records	6,310,428	662,511	723,463	7,696,402		7,696,402	146,354	7,842,756			10
10a	Therapy	373,269		69,835	443,104		443,104	(69,835)	373,269			10a
11	Activities	280,566		16,865	297,431		297,431		297,431			11
12	Social Services	121,622		4,811	126,433		126,433		126,433			12
13	CNA Training											13
14	Program Transportation			122,864	122,864		122,864		122,864			14
15	Other (specify):* Mgmt Co Benefits Alloc							30,490	30,490			15
16	TOTAL Health Care and Programs	7,085,885	662,511	972,838	8,721,234		8,721,234	107,009	8,828,243			16
	C. General Administration											
17	Administrative	256,941		1,109,444	1,366,385		1,366,385	(950,567)	415,818			17
18	Directors Fees											18
19	Professional Services			624,349	624,349		624,349	96,336	720,685			19
20	Dues, Fees, Subscriptions & Promotions			48,195	48,195		48,195	34,656	82,851			20
21	Clerical & General Office Expenses	356,580	124,395	290,289	771,264		771,264	355,546	1,126,810			21
22	Employee Benefits & Payroll Taxes			1,579,387	1,579,387		1,579,387		1,579,387			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,741	5,741		5,741	503	6,244			24
25	Other Admin. Staff Transportation			18,287	18,287		18,287	674	18,961			25
26	Insurance-Prop.Liab.Malpractice			123,369	123,369		123,369	8,717	132,086			26
27	Other (specify):* Mgmt Co Benefits Alloc							95,869	95,869			27
28	TOTAL General Administration	613,521	124,395	3,799,061	4,536,977		4,536,977	(358,266)	4,178,711			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	9,132,397	1,498,096	5,414,820	16,045,313		16,045,313	(246,061)	15,799,252			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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			131,875	131,875		131,875	1,283,910	1,415,785			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			232,017	232,017		232,017	2,058,151	2,290,168			32
33	Real Estate Taxes			819,384	819,384		819,384		819,384			33
34	Rent-Facility & Grounds			4,095,034	4,095,034		4,095,034	(4,051,603)	43,431			34
35	Rent-Equipment & Vehicles			129,641	129,641		129,641	4,463	134,104			35
36	Other (specify):*			152,744	152,744		152,744	110,606	263,350			36
37	TOTAL Ownership			5,560,695	5,560,695		5,560,695	(594,473)	4,966,222			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		485,474	1,877,752	2,363,226		2,363,226	(244,634)	2,118,592			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			586,993	586,993		586,993		586,993			42
43	Other (specify):* Disallowed Costs	266,760	17,052	994,270	1,278,082		1,278,082	(1,278,082)				43
44	TOTAL Special Cost Centers	266,760	502,526	3,459,015	4,228,301		4,228,301	(1,522,716)	2,705,585			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	9,399,157	2,000,622	14,434,530	25,834,309		25,834,309	(2,363,250)	23,471,059			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	(7,132)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,283,268	30		9
10	Interest and Other Investment Income	(9,664)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(164,812)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(10,922)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(776,611)	43		24
25	Fund Raising, Advertising and Promotional	(119,068)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(257,874)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (62,815)		\$	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)	(2,300,435)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (2,300,435)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (2,363,250)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Marketing Salary	\$ (266,760)	43	1
2	Miscellaneous Income offset	(21)	21	2
3	Expense Repairs under \$2,500	2,855	6	3
4	Expense Repairs under \$2,500	10,717	21	4
5	Disallow Marketing Travel Exp	(4,665)	25	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
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38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(257,874)		49

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	20	Licenses and Permits		Norrridge PropCo, LLC	100.00%	\$ 1,615	\$ 1,615	1
2	V	21	Bank Charges		Norrridge PropCo, LLC	100.00%	22,210	22,210	2
3	V	30	Depreciation		Norrridge PropCo, LLC	100.00%			3
4	V	32	Interest		Norrridge PropCo, LLC	100.00%	2,034,584	2,034,584	4
5	V	34	Rent-Facility & Grounds	4,095,034	Norrridge PropCo, LLC	100.00%		(4,095,034)	5
6	V	36	Application Fees		Norrridge PropCo, LLC	100.00%	110,606	110,606	6
7	V	43	Late Fees		Norrridge PropCo, LLC	100.00%	56,301	56,301	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 4,095,034			\$ 2,225,316	\$ * (1,869,718)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	5 Heat and Other Utilities	\$	Premier Healthcare Management, LLC	100.00%	\$ 2,335	\$ 2,335	15
16	V	6 Maintenance		Premier Healthcare Management, LLC	100.00%	6	6	16
17	V	10 Nursing and Medical Records		Premier Healthcare Management, LLC	100.00%	146,354	146,354	17
18	V	15 Emp Benefit Alloc-Healthcare		Premier Healthcare Management, LLC	100.00%	30,490	30,490	18
19	V	17 Administrative	1,109,444	Premier Healthcare Management, LLC	100.00%	158,877	(950,567)	19
20	V	19 Professional Services		Premier Healthcare Management, LLC	100.00%	82,510	82,510	20
21	V	20 Dues, Fees, Subs & Promo		Premier Healthcare Management, LLC	100.00%	612	612	21
22	V	21 Clerical & Gen Office Expenses		Premier Healthcare Management, LLC	100.00%	319,532	319,532	22
23	V	24 Travel and Seminar		Premier Healthcare Management, LLC	100.00%	503	503	23
24	V	25 Other Admin. Staff Trans		Premier Healthcare Management, LLC	100.00%	3,685	3,685	24
25	V	26 Insurance-Prop.Liab.Malpractice		Premier Healthcare Management, LLC	100.00%	232	232	25
26	V	27 Emp Benefit Alloc-Gen Admin		Premier Healthcare Management, LLC	100.00%	95,869	95,869	26
27	V	34 Rent-Facility & Grounds		Premier Healthcare Management, LLC	100.00%	43,431	43,431	27
28	V	35 Equipment Rental		Premier Healthcare Management, LLC	100.00%	4,463	4,463	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		\$ 1,109,444			\$ 888,899	\$ * (220,545)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	10A	Therapy	\$ 69,835	REX Therapeutics	100.00%	\$	(69,835)	15
16	V	19	Professional Services		REX Therapeutics	100.00%	24,748	24,748	16
17	V	20	Fees and Subscriptions		REX Therapeutics	100.00%	32,429	32,429	17
18	V	21	Clerical & General Office Exp		REX Therapeutics	100.00%	3,108	3,108	18
19	V	25	Other Admin Staff Transp		REX Therapeutics	100.00%	1,654	1,654	19
20	V	26	Insurance-Prop.Liab.Malp		REX Therapeutics	100.00%	8,485	8,485	20
21	V	30	Depreciation		REX Therapeutics	100.00%	642	642	21
22	V	32	Interest Expense		REX Therapeutics	100.00%	33,231	33,231	22
23	V	39	Therapy Management Wages		REX Therapeutics	100.00%	64,621	64,621	23
24	V								24
25	V								25
26	V								26
27	V	39	Therapy Wages	1,761,534	REX Therapeutics	100.00%	1,314,934	(446,600)	27
28	V	39	Contract Therapy		REX Therapeutics	100.00%	0		28
29	V	39	Allocated Employee Benefits		REX Therapeutics	100.00%	137,345	137,345	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			\$ 1,831,369			\$ 1,621,197	\$ * (210,172)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Norridge Gardens

0052431

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Barak Bayer	50	Gilman Healthcare Center	Gilman	Premier Healthcare	Skokie	Management Co.	1
2	Ability Insurance Company	35	Winfield Woods Healthcare Center	Winfield	Management, LLC			2
3	SKZ Holdings, Inc.	15	Pershing Gardens Healthcare Center	Stickney	Premier Healthcare	Skokie	Medical Supply	3
4			Gardenview Manor	Danville	Supplies, LLC			4
5			Champaign Urbana Nursing and Rehab	Savoy	REX Therapeutics	Skokie	Therapy	5
6			Premier Healthcare of New Harmony, LLC	New Harmony, IN	Norridge PropCo, LLC	Norridge	Lessor	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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens # 0052431 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 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	Sara Bayer	Relative	Clerical	0.00	See Att Sch 7A	13.75	34.36	Alloc Salary	\$ 15,175	21-7	1
2	Yocheved Bayer	Relative	Consulting	0.00	See Att Sch 7A	N/A	N/A	Consulting	10,800	19-3	2
3	Erez Bayer	Relative	Consulting	5.00	See Att Sch 7A	N/A	N/A	Consulting	60,000	19-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 85,975		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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens# 0052431

Report Period Beginning:

1/1/2020Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Premier Healthcare Management, LLC

Street Address

8170 N. McCormick Blvd. Suite 137

City / State / Zip Code

Skokie, IL 60076

Phone Number

(847) 674-2800

Fax Number

(847) 674-4133

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Heat and Other Utilities	Operating Revenues	64,636,666	8	\$ 6,803	\$	22,192,935	\$ 2,335	1
2	6	Maintenance	Operating Revenues	64,636,666	8	20		22,192,935	6	2
3	10	Nursing and Medical Records	Operating Revenues	64,636,666	8	426,253	426,253	22,192,935	146,354	3
4	15	Emp Benefit Alloc-Healthcare	Operating Revenues	64,636,666	8	88,802		22,192,935	30,490	4
5	17	Administrative	Operating Revenues	64,636,666	8	462,726	462,726	22,192,935	158,877	5
6	19	Professional Services	Operating Revenues	64,636,666	8	65,562		22,192,935	22,510	6
7	20	Dues, Fees, Subs & Promo	Operating Revenues	64,636,666	8	1,782		22,192,935	612	7
8	21	Clerical & Gen Office Expenses	Operating Revenues	64,636,666	8	930,635	877,535	22,192,935	319,532	8
9	24	Travel and Seminar	Operating Revenues	64,636,666	8	1,464		22,192,935	503	9
10	25	Other Admin. Staff Trans	Operating Revenues	64,636,666	8	10,729		22,192,935	3,685	10
11	26	Insurance-Prop.Liab.Malpractice	Operating Revenues	64,636,666	8	675		22,192,935	232	11
12	27	Emp Benefit Alloc-Gen Admin	Operating Revenues	64,636,666	8	279,218		22,192,935	95,869	12
13	34	Rent-Facility & Grounds	Operating Revenues	64,636,666	8	126,494		22,192,935	43,431	13
14	35	Equipment Rental	Operating Revenues	64,636,666	8	12,997		22,192,935	4,463	14
15										15
16	19	Professional Services	Direct Allocation	60,000	1	60,000		60,000	60,000	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,474,160	\$ 1,766,514		\$ 888,899	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens# 0052431

Report Period Beginning:

1/1/2020Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

REX Therapeutics

Street Address

8170 N. McCormick Blvd. Suite 137

City / State / Zip Code

Skokie, IL 60076

Phone Number

(847) 674-2800

Fax Number

(847) 674-4133

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	19	Professional Services	Therapy Revenue	12	\$ 112,512	\$	1,827,620	\$ 24,748	1
2	20	Fees and Subscriptions	Therapy Revenue	12	147,440		1,827,620	32,429	2
3	21	Clerical & General Office Exp	Therapy Revenue	12	14,128		1,827,620	3,108	3
4	25	Other Admin Staff Transp	Therapy Revenue	12	7,522		1,827,620	1,654	4
5	26	Insurance-Prop.Liab.Malp	Therapy Revenue	12	38,581		1,827,620	8,485	5
6	30	Depreciation	Therapy Revenue	12	2,921		1,827,620	642	6
7	32	Interest Expense	Therapy Revenue	12	151,084		1,827,620	33,231	7
8	39	Therapy Management Wages	Therapy Revenue	12	293,802	293,802	1,827,620	64,621	8
9									9
10									10
11									11
12	39	Therapy Wages	Direct Allocation	12	5,424,012	5,424,012	1,314,934	1,314,934	12
13	39	Contract Therapy	Direct Allocation	3	206,555				13
14	39	Allocated Employee Benefits	Total Wages	12	569,187		1,379,555	137,345	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 6,967,744	\$ 5,717,814		\$ 1,621,197	25

SEE ACCOUNTANTS' PREPARATION REPORT

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	FMB		X	Mortgage			32,565,890	32,237,744			2,034,584	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	First Midwest Bank		X	Line of Credit		12/31/14		2,771,550			191,101	6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 32,565,890	\$ 35,009,294			\$ 2,225,685	9	
	B. Non-Facility Related*												
10								Amortization of Loan Costs			1,818	10	
11								Allocated from REX Therapeutics			33,231	11	
12								Offset Interest Income			(9,664)	12	
13								Other Interest Expense			39,098	13	
14	TOTAL Non-Facility Related						\$	\$			\$ 64,483	14	
15	TOTALS (line 9+line14)						\$ 32,565,890	\$ 35,009,294			\$ 2,290,168	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	245,791	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2019		\$	587,287	2
3. Under or (over) accrual (line 2 minus line 1).				\$	341,496	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	348,902	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	128,986	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	819,384	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2015	952,726	8	FOR BHF USE ONLY	
		2016	978,728	9		
		2017	1,035,678	10	13	FROM R. E. TAX STATEMENT FOR 2019 \$ 13
		2018	1,067,795	11	14	PLUS APPEAL COST FROM LINE 5 \$ 14
Accrual based on prior year tax bill.		2019	608,397	12	15	LESS REFUND FROM LINE 6 \$ 15
Adjusted beginning accrual to actual-prior year post closing adjustment					16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' PREPARATION REPORT

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Norridge Gardens COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0052431

CONTACT PERSON REGARDING THIS REPORT Larry Templin

TELEPHONE (630) 361-2868 FAX #: ()

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. 13-18-318-005-0000	Long Term Care Propety	\$ 162,038.13	\$ 162,038.13
2. 13-18-318-006-0000	Long Term Care Propety	\$ 144,497.88	\$ 144,497.88
3. 13-18-318-007-0000	Long Term Care Propety	\$ 145,670.53	\$ 145,670.53
4. 13-18-318-008-0000	Long Term Care Propety	\$ 156,190.62	\$ 156,190.62
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 608,397.16	\$ 608,397.16

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 89,972

B. General Construction Type: Exterior Brick Frame

Number of Stories 4

C. Does the Operating Entity?

☐ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2019	\$ 1,497,000	1
2					2
3	TOTALS			\$ 1,497,000	3

SEE ACCOUNTANTS' PREPARATION REPORT

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	292		2019		\$ 34,717,994	\$	30	\$ 1,157,266	\$ 1,157,266	\$ 1,157,266	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Replace Elevator Door Operator			2013	11,472		20	574	574	3,874	9
10	Replace Pumping Unit			2013	13,952		20	698	698	4,711	10
11	Boiler Repair & Rtu			2013	5,992		20	300	300	4,296	11
12	Build Wood Planters			2013	12,750		20	638	638	4,358	12
13	Sprinkler System Heads & Valves In Parking Lot Foyer & South Dock			2013	3,388		20	169	169	1,156	13
14	Install Awning & Sign			2013	8,944		20	447	447	2,944	14
15	Fire Sprinkler Repair			2014	2,929		20	146	146	950	15
16	Re-Doing Wiring And Computer Systems			2014	22,057		20	1,103	1,103	7,077	16
17	Repair Staircases On All 4 Floors			2014	6,600		20	330	330	2,035	17
18	Install Shunt Trip Breaker & Panelboard For Freight Elevator			2014	6,800		20	340	340	2,097	18
19	Hook Up Emergency Power & Fire Service Wiring			2014	5,010		20	251	251	1,526	19
20	Fire Doors			2014	3,000		20	150	150	900	20
21	Convert 2 Rms On 2Nd Floor To 2 Single Bedrms & Bathrm			2014	70,300		20	3,515	3,515	21,090	21
22	Fire Doors			2014	3,360		20	168	168	1,008	22
23	Water Heater Surface Ignitor			2014	3,957		20	198	198	2,705	23
24	Hot Water Pump Motor			2014	2,500		20	125	125	760	24
25	Install New Elevator Care Doors			2014	2,669		20	133	133	1,644	25
26	Install New Elevator Care Doors			2014	2,669		20	133	133	1,422	26
27	All Areas Carpet & Millwork Cove Base, Bathroom Tile			2014	31,551		20	1,578	1,578	9,467	27
28	Install New Elevator Care Doors			2014	2,669		20	133	133	788	28
29	Fire Alarm System			2014	4,270		20	214	214	1,194	29
30	Sprinkler System Repair			2014	2,523		20	126	126	714	30
31	Fire Alarm Repair			2014	3,264		20	163	163	1,006	31
32	Replace Packing & Repair Leaking Valves			2014	2,974		20	149	149	868	32
33	Hot Water Storage Tank Replacement With Wiring/Piping			2015	7,500		20	375	375	2,250	33
34	Idph Construction Application/Architects/Hvac/Electrical/Sprinkler			2015	8,496		20	425	425	2,550	34
35	Provide/Install New A/C Unit/Electrical Wiring For Lunch Room			2015	5,500		20	275	275	1,650	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
SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Norridge Gardens

0052431

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

1	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	Kitchen Cabinets/Counter Tops For 2Nd/3Rd Floor Dining Rooms	2015	2,662		20	133	\$ 133	\$ 798	37
38	Install Cabinets/Countertops/Plumbing For 2Nd/3Rd Floor Dining	2015	\$ 3,550	\$	20	\$ 178	178	1,068	38
39	Structural Engineering/Calculations/Analysis For Floor Addition	2015	7,500		20	375	375	2,250	39
40	Provide/Install New Circuits Quad Outlets In 2Nd/3Rd Floor Spec	2015	2,680		20	134	134	804	40
41	Design Fees For First Floor Remodeling	2015	10,000		20	500	500	3,000	41
42	Replace Relief Device/Leak & Commission Test/Re-Insulate Tank	2015	7,500		20	375	375	2,250	42
43	Amstadter Construction Documents Detailed Architectural Design	2015	10,000		20	500	500	3,000	43
44	First Floor Remodel/Mechanical/Electrical/Plumbing/& Fire Prote	2015	10,000		20	500	500	3,000	44
45	Design Sketches First Floor Plans/Interior Elevations/Ceiling Plan	2015	10,000		20	500	500	3,000	45
46	Remove/Install New Retro Drains/Saddle For Roof/Iso Roofing Co	2015	3,200		20	160	160	960	46
47	Test/Replace Drive In Control System Contractor For Elevator	2015	2,932		20	147	147	882	47
48	Drilling 0-25'/Patching Of Asphalt/Soil Classification/ Project Rev	2015	4,360		20	218	218	1,308	48
49	Fertilization/Planting Flowers/Shrub & Tree Trimming In Back P	2015	2,730		20	137	137	822	49
50	Modify Pit Ladder/Hoistway Doors/Hatch Latch Door Restrictor I	2015	7,358		20	368	368	2,208	50
51	Replace/Repair leaking heat pipes & boiler water lines-2nd & 3rd	2016	4,238		20	212	212	954	51
52	Repaired Heat Exchanger	2016	3,528		20	176	176	792	52
53	Repair and Paint Walls in Office, Conference Rm & Kitchen	2016	5,425		20	271	271	1,220	53
54	Replace Tiles in Therapy Room	2016	3,900		20	195	195	878	54
55	Install Wanderguard Signalling Device	2016	3,454		20	173	173	778	55
56	New Refrigeration System with Indoor Remote Condensing	2016	11,399		20	570	570	2,565	56
57	2 9500 BTU Replacement units and 2 PTAC Units	2016	5,805		20	290	290	1,305	57
58	Carpet/Flooring - Lobby, Business Office, Conference Rm & Ente	2016	4,472		20	224	224	1,008	58
59	Replace Damaged Floor Tiles in Kitchen	2016	2,650		20	133	133	266	59
60	Install New Torsion-Spring Counter Balance Assembly	2016	2,650		20	133	133	266	60
61	Six new PTAC Units	2016	8,745		20	437	437	874	61
62	Install New 20 Ampere Circuitin Admissions Office	2017	5,000		20	250	250	500	62
63	Install 2 New 20 Ampere Circuits in Kitchen and 1 Power Pole	2017	3,500		20	175	175	350	63
64	Air Conditioner Repairs	2017	3,047		20	152	152	304	64
65	Replace Copper Piping and Strainer for Boiler	2017	3,032		20	152	152	304	65
66	Replace Bearing Assembly, Motor and Impeller for Boiler	2017	3,466		20	173	173	346	66
67	Six new PTAC Units	2017	8,553		20	428	428	856	67
68	Sprinkler System Repairs and Modifications - Maint. Office	2017	5,725		20	286	286	572	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 35,148,151	\$		\$ 1,178,777	\$ 1,178,777	\$ 1,281,794	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Norridge Gardens

0052431

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 35,148,151	\$		\$ 1,178,777	\$ 1,178,777	\$ 1,281,794	1
2	Replace Sink and Cabinets in Utility Rm/Flooring in Ent Rm	2017	3,682		20	184	184	644	2
3	Luna Lights System	2017	4,000		20	200	200	700	3
4	Furnace Repairs	2017	4,680		20	234	234	819	4
5	Architectural Design Plan Revisions	2017	9,780		20	489	489	1,223	5
6	8 PTAC Units	2018	11,263		20	563	563	1,408	6
7	Rewire items from Emergency to Critical Electrical Panel	2018	2,525		20	126	126	315	7
8	4 PTAC Units	2018	5,631		20	282	282	705	8
9	5 PTAC Units	2018	7,039		20	352	352	880	9
10	Replace 2 Flue Caps	2018	4,569		20	228	228	570	10
11	Elevator Repair	2018	4,303		20	215	215	538	11
12	Repair to Boiler	2019	2,731		20	137	137	205	12
13	Re-Piping 7 Front Offices	2019	16,594		20	830	830	1,245	13
14	Repair Pipes due to Freezing	2019	41,484		20	2,074	2,074	3,111	14
15	Install Solid State Soft Starter	2019	3,460		20	173	173	260	15
16	Install New Pump Motor on Elevator	2019	5,592		20	280	280	420	16
17	Replace Heat Coils-Kitchen, Laundry, Front Lobby	2019	18,887		20	944	944	1,416	17
18	Replace Compressor	2019	4,192		20	210	210	315	18
19	Generator Repair	2019	3,059		20	153	153	229	19
20	Replace Hanging Heaters, Connect Thermostat to Heater	2020	2,675		20	67	67	67	20
21	Additions to Emergency Generator-Walk in Cooler	2020	13,475		20	337	337	337	21
22	Repair Hot Water Piping and Installed New Pipes	2020	3,096		20	77	77	77	22
23	Remove Corroded Hot Water Piping	2020	6,382		20	160	160	160	23
24	Repair Hot Water Piping and Installed New Pipes	2020	3,063		20	77	77	77	24
25	Remove Wall Paper	2020	4,000		20	100	100	100	25
26	Pump Replacement	2020	4,000		20	100	100	100	26
27	3 New PTAC Units for Resident Rooms	2020	4,223		20	106	106	106	27
28									28
29	Allocated from Premier Healthcare Management LLC.	2013	8,545		20	427	427	2,645	29
30									30
31	Allocated from REX Therapeutics					642	642		31
32									32
33	Financial Statement Depreciation			81,074			(81,074)		33
34	TOTAL (lines 1 thru 33)		\$ 35,351,081	\$ 81,074		\$ 1,188,544	\$ 1,107,470	\$ 1,300,466	34

SEE ACCOUNTANTS' PREPARATION REPORT

**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	\$ 2,241,540	\$ 44,603	\$ 224,154	\$ 179,551	10 yrs	\$ 478,194	71
72	Current Year Purchases	30,870	6,198	3,087	(3,111)	10 yrs	3,087	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,272,410	\$ 50,801	\$ 227,241	\$ 176,440		\$ 481,281	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	N/A									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)	\$ 39,120,491	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 131,875	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,415,785	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,283,910	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,781,747	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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	Allocated from Management Co.				43,431			5
6								6
7	TOTAL				\$43,431			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
- N/A

N/A

9. Option to Buy:
- ☐ YES☐ NO
- Terms: N/A*

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: \$129,641
- Description: See Attached Schedule 14A
- (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	Allocated from Management Co			4,463	19
20					20
21	TOTAL		\$	\$4,463	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name:Norrridge Gardens

IDPH License ID Number:0052431

Fiscal Year End:12/31/2020

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Nursing Equipment	121,769
Office Equipment	7,872
Total - Line 16	129,641

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

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(7)	13608 hrs	\$ 493,534		\$	\$	13,608	\$ 493,534	1
2	Licensed Speech and Language Development Therapist	39(7)	4480 hrs	162,476				4,480	162,476	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 (7)	18168 hrs	658,924				18,168	658,924	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				483,625		483,625	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Therapy Manager-Allo	39(7)	461	64,621				461	64,621	12
13	Other (specify): See Attached Sch 16A					70,784	1,849		72,633	13
14	TOTAL			\$ 1,379,555		\$ 70,784	\$ 485,474	36,717	\$ 1,935,813	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name:

Norridge Gardens

IDPH License ID Number:

0052431

Fiscal Year End:

12/31/2020

Schedule 16A

XIV. Special Services
Line 13 Other Services

Description	Schedule V	Amount
	Line & Column Reference	
Lab & Xray	39(3)	70,784
Medical Supplies - MCA	39(2)	1,849
Total - Line 13		72,633

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 555,074	\$ 842,517	1
2	Cash-Patient Deposits	3,609	3,609	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 967,605)	6,061,928	7,929,088	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	50,538	50,538	6
7	Other Prepaid Expenses	240,585	240,585	7
8	Accounts Receivable (owners or related parties)	5,546,463	(917,763)	8
9	Other(specify): Due from Others	240,785	240,785	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 12,698,982	\$ 8,389,359	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,497,000	13
14	Buildings, at Historical Cost		34,717,994	14
15	Leasehold Improvements, at Historical Cost	859,454	633,087	15
16	Equipment, at Historical Cost	703,623	2,272,410	16
17	Accumulated Depreciation (book methods)	(925,828)	(1,781,747)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(59,623)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule 17A	775,702	2,124,808	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,412,951	\$ 39,403,929	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 14,111,933	\$ 47,793,288	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,987,920	\$ 3,004,625	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,771,550	2,771,550	29
30	Accrued Salaries Payable	994,297	994,297	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,077,237	1,077,237	31
32	Accrued Real Estate Taxes(Sch.IX-B)		348,902	32
33	Accrued Interest Payable	(52,252)	42,330	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	2,825,359	2,825,359	36
37	Accrued Rent	1,765,328	1,765,328	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 12,369,439	\$ 12,829,628	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		32,237,744	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)	\$	\$ 32,237,744	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 12,369,439	\$ 45,067,372	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,742,494	\$ 2,725,916	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 14,111,933	\$ 47,793,288	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Facility Name:Norrridge Gardens

IDPH License ID Number:0052431

Fiscal Year End:12/31/2020

Schedule 17A

XV. Balance Sheet

Line 23 Other Assets (specify):

	After	
Description	Operating	Consolidation
CapEx Reserve	48,828	48,828
Prepaid Loan Costs	46,760	46,760
Unamortized Loan Costs	278,414	395,504
Escrow Deposits	401,700	1,633,716
Total - Line 23	775,702	2,124,808

Line 36 Other Current Liabilities (specify):

	After	
Description	Operating	Consolidation
Accrued Expenses	120,867	120,867
Accrued Bed Tax	69,298	69,298
Payroll Withholdings	(77,818)	(77,818)
Security Deposits	351,178	351,178
Due to HFS	509,250	509,250
Due to Medicare	1,806,799	1,806,799
Due to Others	30,000	30,000
Due to Prior Owner	15,785	15,785
Total - Line 36	2,825,359	2,825,359

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 827,745	1
2	Restatements (describe):		2
3	See Attached Schedule 18A	(1,012,489)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (184,744)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,927,238	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,927,238	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)	\$ 1,742,494	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: Norridge Gardens
IDPH License ID Number: 0052431
Fiscal Year End: 12/31/2020

Schedule 18A

XVI. STATEMENT OF CHANGES IN EQUITY

Restatements (describe):

Description	Amount
Post closing adjustments -Interest on Capital Lease	511,119
Post closing adjustments - Forgiveness of Debt	(437,586)
Post closing adjustments -Depr/Amort	522,806
Post closing adjustments -Bad Debts	1,931,848
Post closing adjustments -Laundry Service	170,213
Post closing adjustments -Real Estate Taxes	(245,792)
Post closing adjustments -Bank Charges	6,723
Post closing adjustments -Housekeeping Service	267,373
Post closing adjustments -Rent	(906,100)
Post closing adjustments -Gain on Lease Obligation	(808,115)
Total	1,012,489

Facility Name & ID Number Norridge Gardens

0052431

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 18,553,898	1
2	Discounts and Allowances for all Levels	2,859,378	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 21,413,276	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	712,653	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 712,653	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	5,533,927	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	4,050	16
17	Sale of Drugs	64,860	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	(97)	20
21	Other Medical Services	(1,807)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 5,600,933	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,664	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,664	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	21	28
28a	<u>Vendor Dispute Settlement</u>	25,000	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 25,021	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 27,761,547	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,787,102	31
32	Health Care	8,721,234	32
33	General Administration	4,536,977	33
	B. Capital Expense		
34	Ownership	5,560,695	34
	C. Ancillary Expense		
35	Special Cost Centers	3,641,308	35
36	Provider Participation Fee	586,993	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 25,834,309	40
41	Income before Income Taxes (line 30 minus line 40)**	1,927,238	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,927,238	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 10,805,672	44
45	Private Pay - Net Inpatient Revenue	1,723,991	45
46	Medicare - Net Inpatient Revenue	6,723,835	46
47	Other-(specify) <u>Insurance</u>	1,792,143	47
48	Other-(specify) <u>Hospice</u>	367,635	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 21,413,276	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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	1,931	2,113	\$ 128,863	\$ 60.99	1
2	Assistant Director of Nursing	4,824	5,372	252,574	47.02	2
3	Registered Nurses	58,980	63,199	2,298,354	36.37	3
4	Licensed Practical Nurses	28,921	30,224	1,126,305	37.27	4
5	CNAs & Orderlies	113,063	124,879	2,263,445	18.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	14,025	16,002	373,269	23.33	8
9	Activity Director					9
10	Activity Assistants	14,494	15,408	280,566	18.21	10
11	Social Service Workers	5,000	5,642	121,622	21.56	11
12	Dietician					12
13	Food Service Supervisor	1,155	1,167	64,364	55.15	13
14	Head Cook					14
15	Cook Helpers/Assistants	40,787	45,777	696,868	15.22	15
16	Dishwashers					16
17	Maintenance Workers	5,715	6,400	134,487	21.01	17
18	Housekeepers	28,958	32,439	537,272	16.56	18
19	Laundry					19
20	Administrator	2,056	2,080	184,166	88.54	20
21	Assistant Administrator	2,024	2,080	72,775	34.99	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,579	20,223	356,580	17.63	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	2,283	2,459	92,509	37.62	31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	7,652	8,387	415,138	49.50	33
34	TOTAL (lines 1 - 33)	350,447	383,851	\$ 9,399,157 *	\$ 24.49	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	\$ 92,200	L1, C3	35
36	Medical Director	Monthly	35,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant			L10, C3	38
39	Pharmacist Consultant	Monthly	16,422	L10, C3	39
40	Physical Therapy Consultant			L39,C7	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	696	45,434	L10A, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	32	4,811	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	728	\$ 193,867		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,243	\$ 213,120	L10, C3	50
51	Licensed Practical Nurses	1,984	108,482	L10, C3	51
52	Certified Nurse Assistants/Aides	11,003	385,439	L10, C3	52
53	TOTAL (lines 50 - 52)	15,230	\$ 707,041		53

SEE ACCOUNTANTS' PREPARATION REPORT

Norridge Gardens

Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	3,756	4,227	148,378	35.10
Marketing	3,896	4,160	266,760	64.13
TOTAL	7,652	8,387	415,138	

Facility Name: Norridge Gardens
IDPH License ID Number: 0052431
Fiscal Year End: 12/31/2020

Schedule 21A

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
Ability Network Inc	Data Processing	4,758
Baver, Yocheved	Computer Services	10,800
Blymas Inc.	Tax Credit Consultant	1,530
Change Healthcare	Data Processing	352
Collaborative Healthcare Urgency Grou	Healthcare Emergency Preparedness	1,400
E-Solutions	Data Processing	2,287
Experian Health Inc	Revenue Cycle Management	288
GCHMO, Inc.	Managed Care Contracting Services	19,800
HDSI	Data Processing	1,861
Healthcare Solutions Group	Benefits consultant	14,417
Matrixcare	Data Processing	122,677
Paycor	Payroll Processing	42,447
TaxSaver Plan	Benefits Administration	535
Resolute Healthcare Solutions	Healthcare Billing	25,089
Dyatech, LLC	Benefits Consultant	1,150
First Midwest Bank	Field Audit	575
InPath Security, LLC	Data Processing	47,422
Sedgewick	Claims Management	700
Stout Risius Ross, Inc	Appraisal Fees	5,514
Accrual at YE	Appraisal Fees	9,500
Total		313,102

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A

(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. \$ 74,731 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. \$ 586,993
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. \$ 6,302 Has any meal income been offset against related costs? N/A 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% Line 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.

SEE ACCOUNTANTS' PREPARATION REPORT