

		FOR BHF USE					

LL1

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: 0051912

Facility Name: Ridgeview Care Center

Address: 413 Ridge Lane Oblong 62449
Number City Zip Code

County: Crawford

Telephone Number: (618) 592-4228 Fax # (618) 592-3026

HFS ID Number:

Date of Initial License for Current Owners: 11/01/1980

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: Curt Benson, CPA Telephone Number: (812) 882-7730
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 12/31/2020 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) Sarah Griesemer
(Title) Administrator

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) COMPILATION REPORT IS ATTACHED
(Firm Name & Address) Kemper CPA Group LLP
802 Old Wheatland Rd, PO Box 297, Vincennes, IN
(Telephone) (812) 882-7730 Fax # (812) 882-7778

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ridgeview Care Center

0051912 Report Period Beginning: 01/01/2020 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 10/2/2019

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	55	Skilled (SNF)	55	20,130
2		Skilled Pediatric (SNF/PED)		
3		Intermediate (ICF)		
4		Intermediate/DD		
5		Sheltered Care (SC)		
6		ICF/DD 16 or Less		
7	55	TOTALS	55	20,130

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		7,329	2,029	9,358	8
9 SNF/PED					9
10 ICF	7,827			7,827	10
11 ICF/DD					11
12 SC					12
13 DD 16 OR LESS					13
14 TOTALS	7,827	7,329	2,029	17,185	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.37%

D. How many bed reserve days during this year were paid by the Department? 41 (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) Non

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 X

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

I. On what date did you start providing long term care at this location? Date started 11/01/1980

J. Was the facility purchased or leased after January 1, 1978? YES X Date 11/01/1980 NO

K. Was the facility certified for Medicare during the reporting year? YES X NO If YES, enter number of beds certified 55 and days of care provided 2,029

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCUAL X MODIFIED CASH* CASH*

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ridgeview Care Center # 0051912 Report Period Beginning: 01/01/2020 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	198,111	23,589	2,304	224,004		224,004		224,004			1
2	Food Purchase		150,532		150,532		150,532	(318)	150,214			2
3	Housekeeping	96,110	21,947		118,057		118,057		118,057			3
4	Laundry	53,032	2,774		55,806		55,806		55,806			4
5	Heat and Other Utilities			53,020	53,020		53,020	(4,422)	48,598			5
6	Maintenance	39,247	27,011	30,949	97,207		97,207		97,207			6
7	Other (specify):* Biohaz Waste Rem			6,619	6,619		6,619		6,619			7
8	TOTAL General Services	386,500	225,853	92,892	705,245		705,245	(4,740)	700,505			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,255,499	222,020		1,477,519		1,477,519		1,477,519			10
10a	Therapy			353,501	353,501		353,501		353,501			10a
11	Activities	48,271	1,606	252	50,129		50,129		50,129			11
12	Social Services	36,191		252	36,443		36,443		36,443			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Care Plan Coordnt	61,078			61,078		61,078		61,078			15
16	TOTAL Health Care and Programs	1,401,039	223,626	360,005	1,984,670		1,984,670		1,984,670			16
	C. General Administration											
17	Administrative	94,718			94,718		94,718		94,718			17
18	Directors Fees											18
19	Professional Services			23,723	23,723		23,723	(827)	22,896			19
20	Dues, Fees, Subscriptions & Promotions			34,389	34,389		34,389	(16,563)	17,826			20
21	Clerical & General Office Expenses	27,483	23,585	26,201	77,269		77,269	(8,640)	68,629			21
22	Employee Benefits & Payroll Taxes			206,884	206,884		206,884		206,884			22
23	Inservice Training & Education			764	764		764		764			23
24	Travel and Seminar			313	313		313		313			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			52,016	52,016		52,016		52,016			26
27	Other (specify):* Bad Debts			39,675	39,675		39,675	(39,675)				27
28	TOTAL General Administration	122,201	23,585	383,965	529,751		529,751	(65,705)	464,046			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,909,740	473,064	836,862	3,219,666		3,219,666	(70,445)	3,149,221			29

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

SEE ACCOUNTANTS' COMPILATION 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			43,668	43,668	2,880	46,548	(1,543)	45,005			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			37,316	37,316		37,316		37,316			33
34	Rent-Facility & Grounds			45,600	45,600	(2,880)	42,720	(42,720)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			8,992	8,992		8,992	(8,992)				36
37	TOTAL Ownership			135,576	135,576		135,576	(53,255)	82,321			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			180	180		180		180			39
40	Barber and Beauty Shops			23	23		23		23			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			112,514	112,514		112,514		112,514			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			112,717	112,717		112,717		112,717			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,909,740	473,064	1,085,155	3,467,959		3,467,959	(123,700)	3,344,259			45

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

SEE ACCOUNTANTS' COMPILATION 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	(4,422)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(318)	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				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(827)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(39,675)	27		24
25	Fund Raising, Advertising and Promotional	(10,944)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(8,992)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(15,802)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (80,980)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (80,980)		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

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Late Fees	\$ (5,569)	20	1
2	Non-care Asset Depreciation	(1,543)	30	2
3	Dues	(50)	20	3
4	Miscellaneous	(8,640)	21	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	(15,802)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Ridgeview Care Center

0051912

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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	(318)	0	0	0	0	0	0	0	0	0	0	(318)	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	(4,422)	0	0	0	0	0	0	0	0	0	0	(4,422)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,740)	0	0	0	0	0	0	0	0	0	0	(4,740)	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	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(827)	0	0	0	0	0	0	0	0	0	0	(827)	19
20	Fees, Subscriptions & Promotions	(16,563)	0	0	0	0	0	0	0	0	0	0	(16,563)	20
21	Clerical & General Office Expenses	(8,640)	0	0	0	0	0	0	0	0	0	0	(8,640)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(39,675)	0	0	0	0	0	0	0	0	0	0	(39,675)	27
28	TOTAL General Administration	(65,705)	0	0	0	0	0	0	0	0	0	0	(65,705)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(70,445)	0	0	0	0	0	0	0	0	0	0	(70,445)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Ridgeview Care Center # 0051912 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	(1,543)	0	0	0	0	0	0	0	0	0	0	(1,543)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(42,720)	0	0	0	0	0	0	0	0	0	(42,720)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(8,992)	0	0	0	0	0	0	0	0	0	0	(8,992)	36
37	TOTAL Ownership	(10,535)	(42,720)	0	0	0	0	0	0	0	0	0	(53,255)	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)	(80,980)	(42,720)	0	0	0	0	0	0	0	0	0	(123,700)	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
Eileen Cunningham	50					
Cindy Bell	25					
Jenny Pargin	25					

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	Facility Rental	\$ 22,800	Eileen Cunningham	50.00%	\$ 2,880	\$ (19,920)	1
2	V	34	Facility Rental	11,400	Cindy Bell	25.00%		(11,400)	2
3	V	34	Facility Rental	11,400	Jenny Pargin	25.00%		(11,400)	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 45,600			\$ 2,880	\$ * (42,720)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ridgeview Care Center # 0051912 Report Period Beginning: 01/01/2020 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	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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' COMPILATION REPORT

Facility Name & ID Number Ridgeview Care Center # 0051912 Report Period Beginning: 01/01/2020 Ending: 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 X

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

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

SEE ACCOUNTANTS' COMPILATION 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	N/A						\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	N/A												6
7													7
8													8
9	TOTAL Facility Related						\$		\$			\$	9
	B. Non-Facility Related*												
10	N/A												10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$		\$			\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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.) SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

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.	\$	34,500	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.)			\$	35,716	2
3. Under or (over) accrual (line 2 minus line 1).			\$	1,216	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	36,100	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	37,316	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	36,983	8	
		2016	37,007	9	
		2017	36,420	10	
		2018	35,235	11	
		2019	35,716	12	
2. 2019 tax year, payable 2020.				13	FROM R. E. TAX STATEMENT FOR 2019 \$ 13
4. Accrual based on a 1% increase (rounded) in real estate property taxes for 2020 payable 2021.				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				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' COMPILATION REPORT

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Ridgeview Care Center COUNTY Crawford

FACILITY IDPH LICENSE NUMBER 0051912

CONTACT PERSON REGARDING THIS REPORT Curt Benson, CPA

TELEPHONE (812) 882-7730 FAX #: (812) 882-7778

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)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1. 04-4-06-010-048-000	Facility in Village of Oblong	\$ 35,716.00	\$ 35,716.00
2.	PT NW NW EXC 80' x 280' off	\$	\$
3.	W End (.51A) SEC 6-6-13	\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 35,716.00	\$ 35,716.00

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

153,900

B. General Construction Type:

Exterior

Brick

Frame

Concrete Block

Number of Stories

1

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

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	153,900	1972	\$ 5,875	1
2					2
3	TOTALS	153,900		\$ 5,875	3

SEE ACCOUNTANTS' COMPILATION 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	29			1975	\$ 206,038	\$		\$		\$ 206,038
5	26			1986	496,899					496,899
6										
7										
8										
	Improvement Type**									
9	Various Fully Depreciated Assets Through 2020				16,366					16,366
10	Transfer Switch			2007	2,954	197	15	197		2,757
11	Alarm System			2007	15,431	1,029	15	1,029		13,633
12	Plumbing and Wall Repairs			2009	3,088	154	20	154		1,837
13	Sprinkler System			2011	37,500	1,500	25	1,500		13,875
14	Boiler (LLC)			2014	6,256	312	20	312		2,189
15	Roof Replacement (LLC)			2015	138,916	13,891	10	13,891		85,664
16	Windows (LLC)			2015	30,722	1,536	20	1,536		8,320
17	Roof Replacement - Section 3 (LLC)			2015	38,352	3,835	10	3,835		19,495
18	Courtyard Pavilion Wall & Roof Repairs (LLC)			2016	5,108	341	15	341		1,533
19	Nurse's Station & Wall Repairs (LLC)			2017	4,110	274	15	274		1,073
20	Boiler - NTI (LLC)			2018	5,412	271	20	271		587
21	Front Door With Sidelites			2020	4,808	140	20	140		140
22	Parking Lot Paving & Sidewalk Overlay			2020	12,798	667	8	667		667
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
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' COMPILATION REPORT

Facility Name & ID Number Ridgeview Care Center

0051912

Report Period Beginning:

01/01/2020 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 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,024,758	\$ 24,147		\$ 24,147	\$	\$ 871,073	70

SEE ACCOUNTANTS' COMPILATION 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	\$ 219,480	\$ 20,858	\$ 20,858	\$		\$ 138,702	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	5,091					5,091	73
74								74
75	TOTALS	\$ 224,571	\$ 20,858	\$ 20,858	\$		\$ 143,793	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)	\$ 1,255,204	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 45,005	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 45,005	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,014,866	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	2015 Ford Focus - Acq. 2015	\$ 18,514	\$ 1,543	\$ 18,514	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 18,514	\$ 1,543	\$ 18,514	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.

SEE ACCOUNTANTS' COMPILATION 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								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

* 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' COMPILATION REPORT

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' COMPILATION 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	10a-3	hrs	\$	1,707	\$ 116,047	\$	1,707	\$ 116,047	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,521	103,440		1,521	103,440	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		2,234	134,014		2,234	134,014	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	5,462	\$ 353,501	\$	5,462	\$ 353,501	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' COMPILATION REPORT

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,673,562	\$	1
2	Cash-Patient Deposits	1,851		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,122,912		3
4	Supply Inventory (priced at cost)	5,779		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Empl. Loans</u>	1,250		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,805,354	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	246,482		15
16	Equipment, at Historical Cost	243,085		16
17	Accumulated Depreciation (book methods)	(281,976)		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)	\$ 207,591	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,012,945	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 116,405	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,851		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	84,437		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	36,100		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	8,992		35
	Other Current Liabilities(specify):			
36	<u>Distributions Payable</u>	50,000		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 297,785	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 297,785	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,715,160	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,012,945	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,443,122	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,443,122	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	872,038	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	(600,000)	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)	\$ 272,038	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)	\$ 2,715,160	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Ridgeview Care Center

0051912

Report Period Beginning: 01/01/2020

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	\$ 3,540,839	1
2	Discounts and Allowances for all Levels	(4,217)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,536,622	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	859	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)	\$ 859	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12,769	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12,769	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Provider Relief/PPP Loan Proceeds	788,720	28
28a	Miscellaneous Income	1,027	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 789,747	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,339,997	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	705,245	31
32	Health Care	1,984,670	32
33	General Administration	529,751	33
	B. Capital Expense		
34	Ownership	135,576	34
	C. Ancillary Expense		
35	Special Cost Centers	203	35
36	Provider Participation Fee	112,514	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,467,959	40
41	Income before Income Taxes (line 30 minus line 40)**	872,038	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 872,038	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 968,894	44
45	Private Pay - Net Inpatient Revenue	1,598,935	45
46	Medicare - Net Inpatient Revenue	968,793	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,536,622	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' COMPILATION 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	2,673	2,868	\$ 140,514	\$ 48.99	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,884	6,332	161,999	25.58	3
4	Licensed Practical Nurses	11,249	11,738	285,938	24.36	4
5	CNAs & Orderlies	44,297	40,782	631,954	15.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,344	3,624	48,271	13.32	9
10	Activity Assistants					10
11	Social Service Workers	1,901	2,112	36,191	17.14	11
12	Dietician					12
13	Food Service Supervisor	2,050	2,208	35,442	16.05	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,124	15,529	162,669	10.48	15
16	Dishwashers					16
17	Maintenance Workers	1,994	2,152	39,247	18.24	17
18	Housekeepers	7,770	8,199	96,110	11.72	18
19	Laundry	4,877	5,105	53,032	10.39	19
20	Administrator	2,071	2,080	94,718	45.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	809	902	27,483	30.47	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	1,897	2,287	35,094	15.34	31
32	Other Health Care(specify)					32
33	Other(specify) Care Plan Coord	2,189	2,314	61,078	26.39	33
34	TOTAL (lines 1 - 33)	108,129	108,232	\$ 1,909,740 *	\$ 17.64	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	96	\$ 2,304		35
36	Medical Director	120	6,000		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	4	252		44
45	Social Service Consultant	4	252		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	224	\$ 8,808		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Sarah Griesemer	Administrator	0	\$ 94,718
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 94,718
B. Administrative - Other			
Description			Amount
			\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
Kemper CPA Group LLP	Accounting Services	\$	20,800
Sandberg Phoenix	Professional Services		312
Goldneberg Heller & Antognoli	Professional Services		515
ADP	Payroll Services		2,096
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 23,723
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	27,700
Unemployment Compensation Insurance			5,322
FICA Taxes			138,706
Employee Health Insurance			17,108
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Employer IRA Match			17,373
Miscellaneous			675
TOTAL (agree to Schedule V, line 22, col.8)			\$ 206,884
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
		\$	
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	
Advertising: Employee Recruitment			
Health Care Worker Background Check (Indicate # of checks performed)	9		465
Patient Background Checks	29		528
Advertising			10,944
Dues & Subscriptions			8,163
Licenses & Fees			9,936
Employee Physicals			4,353
Less: Late Fees			(5,569)
Less: Public Relations Expense			(50)
Non-allowable advertising			(10,944)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 17,826
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			28
Seminar Expense			285
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	313

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT**

****See instructions.**

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. _____
- (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? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line _____
- (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. \$ 112,514
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? N/A
- (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? No 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? 100
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
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. \$ _____
- (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.

SEE ACCOUNTANTS' COMPILATION REPORT

Attachment to Schedule XIII, Page 15.
Expenses Related to Certified Nurses Aid Training Programs

Item A, #1

The facility only hires fully-trained Certified Nurses Aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Fixed Assets Reconciliation
Pages 12-13 - Schedule XI Ownership Costs

	<u>Land</u>	<u>Building & Improvements</u>	<u>Leasehold Improvements</u>	<u>Equipment & Vehicles</u>	<u>Total</u>
Schedule XV Balance Sheet	\$ -	\$ -	\$ 246,482	\$ 243,085	\$ 489,567
Schedule XI - Non-Care Assets	-	-	-	18,514	18,514
Schedule XI - Care-Related Assets	<u>5,875</u>	<u>1,024,758</u>	<u>-</u>	<u>224,571</u>	<u>1,255,204</u>
Difference	<u>\$ (5,875)</u>	<u>\$ (1,024,758)</u>	<u>\$ 246,482</u>	<u>\$ -</u>	<u>\$ (784,151)</u>

On January 1, 2012, Ridgeview Care Center LLC was organized. The real estate, building, and building improvements (prior to 2012) were not included. The facility is rented from related parties.

SEE ACCOUNTANTS' COMPILATION REPORT

Schedule V. Cost Center Expenses - Reclassifications

Cost Center	Line	Increase	Decrease
Depreciation	30	\$ 2,880	
Rent-Facility & Grounds	34		\$ 2,880

(Reclassify depreciation expense from rent-facility & grounds)

SEE ACCOUNTANTS' COMPILATION REPORT.