

		FOR BHF USE					

LL1

2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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 Facility ID Number: 0032011

Facility Name: Norridge Hlthcr & Rehab Centre

Address: 7001 West Cullom Ave. Norridge 60706
 Number City Zip Code

County: Cook

Telephone Number: (708) 457-0700 Fax # (708) 457-8852

HFS ID Number: 36-3485852

Date of Initial License for Current Owners: 1-Jan-1987

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Christopher Vicere **Telephone Number:** (773) 604-4416

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1-Jan-2006 to 31-Dec-2006 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.

(Signed) _____ 29th March 2007
 (Date)

Officer or Administrator of Provider
 (Type or Print Name) Christopher Vicere
 (Title) Vice President - Finance

(Signed) _____
 (Date)

Paid Preparer
 (Print Name and Title) _____
 (Firm Name & Address) _____
 (Telephone) () 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

Facility Name & ID Number Norridge Hlthcr & Rehab Centre# 0032011 Report Period Beginning: 1-Jan-2006 Ending: 31-Dec-2006

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 bedsN/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>210</u>	Skilled (SNF)	<u>210</u>	<u>76,650</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>105</u>	Intermediate (ICF)	<u>105</u>	<u>38,325</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>315</u>	TOTALS	<u>315</u>	<u>114,975</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>63,799</u>	<u>9,039</u>	<u>16,018</u>	<u>88,856</u>	8
9	SNF/PED					9
10	ICF	<u>4,400</u>	<u>365</u>		<u>4,765</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>68,199</u>	<u>9,404</u>	<u>16,018</u>	<u>93,621</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 81.43%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 1-Jan-1987

J. Was the facility purchased or leased after January 1, 1978?

YES Date 1-Jan-1987 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number
of beds certified 210 and days of care provided 15,389Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED
CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 31st Dec 2006 Fiscal Year: 31st Dec 2006

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

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-2006 Ending: 31-Dec-2006

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 OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	620,985	60,137	21,346	702,468		702,468		702,468			1
2	Food Purchase		589,042		589,042	(23,068)	565,974	(470)	565,504			2
3	Housekeeping	379,551	104,658		484,209		484,209		484,209			3
4	Laundry	187,959	85,125		273,084		273,084		273,084			4
5	Heat and Other Utilities			339,925	339,925		339,925		339,925			5
6	Maintenance	100,314	67,546	134,395	302,255		302,255		302,255			6
7	Other (specify):*											7
8	TOTAL General Services	1,288,809	906,508	495,666	2,690,983	(23,068)	2,667,915	(470)	2,667,445			8
	B. Health Care and Programs											
9	Medical Director			42,000	42,000		42,000		42,000			9
10	Nursing and Medical Records	5,352,397	771,929	109,265	6,233,591		6,233,591		6,233,591			10
10a	Therapy			8,706	8,706		8,706		8,706			10a
11	Activities	164,899	20,392	427	185,718		185,718		185,718			11
12	Social Services	91,555		4,226	95,781		95,781		95,781			12
13	CNA Training		1,900		1,900		1,900		1,900			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,608,851	794,221	164,624	6,567,696		6,567,696		6,567,696			16
	C. General Administration											
17	Administrative	130,797		502,740	633,537		633,537	(314,863)	318,674			17
18	Directors Fees											18
19	Professional Services			71,021	71,021		71,021	26,926	97,947			19
20	Dues, Fees, Subscriptions & Promotions			68,024	68,024		68,024	(41,606)	26,418			20
21	Clerical & General Office Expenses	358,013	53,715	101,944	513,672		513,672	46,067	559,739			21
22	Employee Benefits & Payroll Taxes			1,293,861	1,293,861	23,068	1,316,929	17,342	1,334,271			22
23	Inservice Training & Education			11,028	11,028		11,028	3,994	15,022			23
24	Travel and Seminar			7,721	7,721		7,721	6,464	14,185			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			66,858	66,858		66,858		66,858			26
27	Other (specify):* *Payroll Taxes (Sch VII)							34,245	34,245			27
28	TOTAL General Administration	488,810	53,715	2,123,197	2,665,722	23,068	2,688,790	(221,431)	2,467,359			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,386,470	1,754,444	2,783,487	11,924,401		11,924,401	(221,901)	11,702,500			29

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

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

Facility Name & ID Number Norridge Hlthcr & Rehab Centre

#0032011

Report Period Beginning: 1-Jan-2006 Ending:

31-Dec-2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			111,898	111,898		111,898	192,230	304,128			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			30,357	30,357		30,357	1,471,687	1,502,044			32
33	Real Estate Taxes			518,488	518,488		518,488		518,488			33
34	Rent-Facility & Grounds			2,485,799	2,485,799		2,485,799	(2,484,000)	1,799			34
35	Rent-Equipment & Vehicles			3,759	3,759		3,759		3,759			35
36	Other (specify):*											36
37	TOTAL Ownership			3,150,301	3,150,301		3,150,301	(820,083)	2,330,218			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		307,922	1,164,734	1,472,656		1,472,656		1,472,656			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			172,463	172,463		172,463		172,463			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		307,922	1,337,197	1,645,119		1,645,119		1,645,119			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,386,470	2,062,366	7,270,985	16,719,821		16,719,821	(1,041,984)	15,677,837			45

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

Facility Name & ID Number Norridge Hlthcr & Rehab Centre

0032011

Report Period Beginning: 1-Jan-2006

Ending: 31-Dec-2006

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	93,187	30		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	(470)	2		13
14	Non-Care Related Interest		32		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	(2,000)	24		19
20	Contributions		20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(65,163)	21		24
25	Fund Raising, Advertising and Promotional	(92,341)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,440)	20		28
29	Other-Attach Schedule ** Page 5A attached **		6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (69,227)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(972,757)	6 & 6A	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (972,757)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,041,984)		37

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

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

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

BHF USE ONLY					
48		49		50	
				51	
					52

Norridge Hlther & Rehab Centre

ID# 0032011

Report Period Beginning: 1-Jan-2006

Ending: 31-Dec-2006

Sch. V Line

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Norridge Hlthcr & Rehab Centre# 0032011

Report Period Beginning:

1-Jan-2006

Ending:

31-Dec-2006**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(470)	0	0	0	0	0	0	0	0	0	0	(470)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	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	(470)	0	0	0	0	0	0	0	0	0	0	(470)	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	(314,863)	0	0	0	0	0	0	0	0	0	(314,863)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	25,866	1,060	0	0	0	0	0	0	0	0	26,926	19
20	Fees, Subscriptions & Promotions	(94,781)	53,175	0	0	0	0	0	0	0	0	0	(41,606)	20
21	Clerical & General Office Expenses	(65,163)	109,988	1,242	0	0	0	0	0	0	0	0	46,067	21
22	Employee Benefits & Payroll Taxes	0	17,342	0	0	0	0	0	0	0	0	0	17,342	22
23	Inservice Training & Education	0	3,994	0	0	0	0	0	0	0	0	0	3,994	23
24	Travel and Seminar	(2,000)	8,464	0	0	0	0	0	0	0	0	0	6,464	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):*	0	34,245	0	0	0	0	0	0	0	0	0	34,245	27
28	TOTAL General Administration	(161,944)	(61,789)	2,302	0	(221,431)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(162,414)	(61,789)	2,302	0	(221,901)	29							

STATE OF ILLINOIS

Facility Name & ID Number Norridge Hlthcr & Rehab Centre

0032011

Report Period Beginning:

1-Jan-2006 Ending:

Summary B

31-Dec-2006

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	93,187	1,225	97,818	0	0	0	0	0	0	0	0	192,230	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	44,554	1,427,133	0	0	0	0	0	0	0	0	1,471,687	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(2,484,000)	0	0	0	0	0	0	0	0	(2,484,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	93,187	45,779	(959,049)	0	(820,083)	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)	(69,227)	(16,010)	(956,747)	0	(1,041,984)	45							

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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	17 Officers' Salaries	\$	Lancaster, Ltd.	100.00%	\$ 66,598	\$ 66,598 1
2	V	27 Payroll Taxes-Officers & Staff		Lancaster, Ltd.	100.00%	34,245	34,245 2
3	V	17 Management Fee Income	502,740	Lancaster, Ltd.	100.00%		(502,740) 3
4	V	19 Professional Services		Lancaster, Ltd.	100.00%	25,866	25,866 4
5	V	21 Clerical Expenses		Lancaster, Ltd.	100.00%	109,988	109,988 5
6	V	22 Employee Benefits		Lancaster, Ltd.	100.00%	17,342	17,342 6
7	V	24 Seminars & Travel		Lancaster, Ltd.	100.00%	8,464	8,464 7
8	V	17 Administrative Consulting		Lancaster, Ltd.	100.00%	121,279	121,279 8
9	V	20 Marketing and Fees		Lancaster, Ltd.	100.00%	52,049	52,049 9
10	V	32 Interest		Lancaster, Ltd.	100.00%	44,554	44,554 10
11	V	30 Depreciation		Lancaster, Ltd.	100.00%	1,225	1,225 11
12	V	20 Dues, Fees and Subscriptions		Lancaster, Ltd.	100.00%	1,126	1,126 12
13	V	23 Education & Inservice		Lancaster, Ltd.	100.00%	3,994	3,994 13
14	Total		\$ 502,740			\$ 486,730	\$ * (16,010) 14

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

Facility Name & ID Number Norridge Hlthcr & Rehab Centre# 0032011Report Period Beginning: 1-Jan-2006 Ending: 31-Dec-2006

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34 Rental	\$ 2,484,000	Norridge Associates	100.00%	\$	\$ (2,484,000)	15
16	V	32 Interest	72,867	Norridge Associates		1,500,000	1,427,133	16
17	V	30 Depreciation		Norridge Associates		97,818	97,818	17
18	V	21 IL State Replacement Tax		Norridge Associates		1,242	1,242	18
19	V	19 Accounting Fees		Norridge Associates		1,060	1,060	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 2,556,867			\$ 1,600,120	\$ * (956,747)	39

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

Facility Name & ID Number

Norridge Hlthcr & Rehab Centre

#

0032011

Report Period Beginning:

1-Jan-2006

Ending:

31-Dec-2006

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	Christopher Vicere	VP-Finance	Administrative	6.00	See attached	9	18.75	Lancaster	\$ 33,338	17-7	1
2	Cheryl Morris	VP-Operations	Administrative	6.00	See attached	9	18.75	Lancaster	33,260	17-7	2
3	Sandra Bernett	Adminitrator	Administrative	5.00		40	100.00	Lancaster		17-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 66,598		13

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

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

Facility Name & ID Number Norridge Hlthcr & Rehab Centre

0032011

Report Period Beginning:

1-Jan-2006

Ending: -Dec-2006

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 Lancaster, Ltd.
 Street Address 5061 N. Pulaski Road,
 City / State / Zip Code Chicago, IL 60630
 Phone Number (773) 604-4416
 Fax Number (773) 478-1192

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	17	Christopher Vicere	Hours Worked	48	7	\$ 177,802	\$ 177,802	9	\$ 33,338	1
2	27	Christopher Vicere-payroll tax	Hours Worked	48	7	9,454		9	1,773	2
3	17	Cheryl Morris	Hours Worked	48	7	177,385	177,385	9	33,260	3
4	27	Cheryl Morris-payroll tax	Hours Worked	48	7	9,436		9	1,769	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13	19	Professional Services	Management Fees	2,146,620	7	110,443		502,740	25,866	13
14	21	Clerical Expenses	Management Fees	2,146,620	7	469,632	428,989	502,740	109,988	14
15	22	Employee Benefits	Management Fees	2,146,620	7	74,046		502,740	17,342	15
16	24	Seminars & Travel	Management Fees	2,146,620	7	36,138		502,740	8,464	16
17	17	Administrative Consulting	Management Fees	2,146,620	7	517,841	471,840	502,740	121,279	17
18	20	Marketing and Fees	Management Fees	2,146,620	7	222,241	180,200	502,740	52,049	18
19	32	Interest	Management Fees	2,146,620	7	8,729		502,740	2,044	19
20	30	Depreciation	Management Fees	2,146,620	7	5,231		502,740	1,225	20
21	20	Dues, Fees and Subscriptions	Management Fees	2,146,620	7	4,809		502,740	1,126	21
22	27	Payroll Taxes	Management Fees	2,146,620	7	131,096		502,740	30,703	22
23	23	Education & Inservice	Management Fees	2,146,620	7	17,054		502,740	3,994	23
24	32	*Direct Interest*							42,510	24
25	TOTALS					\$ 1,971,337	\$ 1,436,216		\$ 486,730	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6	JP Morgan Chase Bank		X	Working Capital						2,044	6									
7	Harston Investments		X	Working Capital						1,500,000	7									
8											8									
9	TOTAL Facility Related						\$	\$		\$ 1,502,044	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$	14									
15	TOTALS (line 9+line14)						\$	\$		\$ 1,502,044	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.)

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

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

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2005 report.		\$	511,500	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.)		\$	509,988	2
3.	Under or (over) accrual (line 2 minus line 1).		\$	(1,512)	3
4.	Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	520,000	4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	518,488	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:					
	2001	<u>437,929</u>	<u>8</u>		
	2002	<u>438,817</u>	<u>9</u>		
	2003	<u>464,854</u>	<u>10</u>		
	2004	<u>496,535</u>	<u>11</u>		
	2005	<u>509,988</u>	<u>12</u>		
Accrual for 2006 Report is based on 2005 Taxes adjusted for inflation					
				FOR BHF USE ONLY	
	13	FROM R. E. TAX STATEMENT FOR 2005	\$		13
	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Norridge Nursing Centre, Inc. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 32011

CONTACT PERSON REGARDING THIS REPORT Christopher Vicere

TELEPHONE (773) 604 - 4416 FAX #: (773) 478 - 1192

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>13-18-318-005-0000</u>	<u>Long-Term Healthcare</u>	\$ <u>127,301.24</u>	\$ <u>127,301.24</u>
2. <u>13-18-318-006-0000</u>	<u>Long-Term Healthcare</u>	\$ <u>127,301.24</u>	\$ <u>127,301.24</u>
3. <u>13-18-318-007-0000</u>	<u>Long-Term Healthcare</u>	\$ <u>128,084.17</u>	\$ <u>128,084.17</u>
4. <u>13-18-318-008-0000</u>	<u>Long-Term Healthcare</u>	\$ <u>127,301.24</u>	\$ <u>127,301.24</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>509,987.89</u>	\$ <u>509,987.89</u>

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 & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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 Frame Number of Stories

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 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	Nsg.Care Facility		1986	\$ 650,000	1
2	Sect 754 basis adj			126,788	2
3	TOTALS			\$ 776,788	3

Facility Name & ID Number Norridge Hlthcr & Rehab Centre# 0032011

Report Period Beginning:

1-Jan-2006 Ending: 31-Dec-2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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			1986	1976	\$ 9,204,000	\$	30	\$	\$	\$ 7,194,460	4
5					1,315,965	41,777	30	41,777		612,268	5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1987		43,548	1,382	20	2,177	795	41,569	9
10	Various		1988		3,940	125	20	197	72	4,180	10
11	Various		1988		28,574	459	20	724	265	29,969	11
12	Various		1989		1,297	41	20	65	24	1,216	12
13	Various		1990		3,827	121	20	191	70	3,468	13
14	Various		1990		28,644	909	20	1,433	524	23,206	14
15	Various		1991		72,916	2,314	20	3,650	1,336	55,493	15
16	Various		1992		36,639	1,352	20	1,944	592	27,175	16
17	Various		1993		72,513	1,921	20	3,627	1,706	47,708	17
18	Various		1994		116,353	3,049	20	5,854	2,805	69,826	18
19	Various		1995		95,409	2,447	20	4,770	2,323	54,607	19
20	Boiler/Hot Water Heater Improvements		1996		9,417	241	20	471	230	4,950	20
21	Tuckpointing		1999		28,900	741	20	1,445	704	11,298	21
22	Architect Fee 1st Floor		2001		15,052	386	20	386		2,268	22
23	Construction 1st Floor		2001		166,662	4,273	20	4,273		25,105	23
24	Construction Library		2001		12,461	320	20	320		1,879	24
25	Design Fee-1st Floor		2001		5,130	132	20	132		775	25
26	Sprinklers-1st Floor		2001		4,531	116	20	116		682	26
27	Demolition-1st Floor		2001		5,533	142	20	142		834	27
28	Wooden Doors (2)		2001		1,134	29	20	29		171	28
29	Construction Work		2002		4,207	108	20	108		571	29
30	Smoking Shelter		2002		3,251	83	20	325	242	1,625	30
31	Auto Front Door		2002		2,074	53	20	207	154	949	31
32	Fence In Lot		2003		2,972	114	20	198	84	644	32
33	Building New-Town Square		2003		281,539	22,524	20	19,508	(3,016)	61,775	33
34	Roofing		2003		62,440	1,601	20	6,244	4,643	19,773	34
35	Wanderquard		2004		964	164	20	96	(68)	272	35
36	Refuse Inclosure		2004		2,395	423	20	240		560	36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Norridge Hlthcr & Rehab Centre

0032011

Report Period Beginning:

1-Jan-2006 Ending: 31-Dec-2006

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Fire Alarm System	2004	\$ 104,400	\$ 20,045		\$ 14,914	\$ (5,131)	\$ 41,014	37
38	Patio Concrete	2004	2,500	64		250	186	729	38
39	Air Ventilation System	2004	26,794	687		2,233	1,546	5,768	39
40	Design & Development of Town Square	2004	42,130	1,080		4,213	3,133	11,937	40
41	Consultancy Fire Alarm Installation	2004	22,700	4,358		3,243	(1,115)	8,918	41
42	Hand Rail System	2005	6,025	154		603	449	1,105	42
43	Duct Detectors	2005	2,061	53		412	359	756	43
44	20 Ton Roof Top Aircon	2005	17,635	452		3,527	3,075	5,584	44
45	Elevator Fire Upgrade	2005	46,440	1,191		9,288	8,097	14,706	45
46	Concrete Approach Pad	2005	2,160	55		216	161	306	46
47	27 Plastic Laminate Doors	2006	6,145	125		512	387	512	47
48	10T Rooftop A/C W/ Exhaust	2006	24,668	343		1,439	1,096	1,439	48
49	Wanderquard	2006	1,000	3		17	14	17	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)		\$ 11,936,945	\$ 115,957		\$ 141,516	\$ 25,742	\$ 8,392,067	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 987,493	\$ 78,063	\$ 149,995	\$ 71,932	7	\$ 733,051	71
72	Current Year Purchases	51,263	10,254	4,916	(5,338)	7	4,916	72
73	Fully Depreciated Assets	1,180,391	5,442	6,476	1,034	7	1,180,391	73
74	Lancaster Allocation		1,225	1,225		7	11,643	74
75	TOTALS	\$ 2,219,147	\$ 94,984	\$ 162,612	\$ 67,628		\$ 1,930,001	75

D. Vehicle Depreciation (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)		\$ 14,932,880	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 210,941	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 304,128	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 93,187	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 10,322,068	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: ***N/A - Related Party Lease***

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			<u>***Off-site Public Storage***</u>		<u>1,799</u>			5
6								6
7	TOTAL				\$ <u>1,799</u>			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 3,759 Description: Minolta Copier

(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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	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	39-3	hrs	\$		\$ 501,596	\$		\$ 501,596	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			78,396			78,396	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			584,742			584,742	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	39-3	hrs				64,616		64,616	8
9	Pharmacy	39-2	# of prescripts				208,903		208,903	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **Medical Supplies** **Speciality Beds**	39-2 39-2					1,454 32,949		1,454 32,949	13
14	TOTAL			\$		\$ 1,164,734	\$ 307,922		\$ 1,472,656	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Norridge Hlthcr & Rehab Centre# 0032011Report Period Beginning: 1-Jan-2006

Ending:

31-Dec-2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 31-Dec-2006 (last day of reporting year)

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	\$ (176,441)	\$ (176,441)	1
2	Cash-Patient Deposits	83,163	83,163	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	5,060,557	5,060,557	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	94,590	94,590	6
7	Other Prepaid Expenses	750	750	7
8	Accounts Receivable (owners or related parties)		1,347,616	8
9	Other(specify): <u>Employee Advances</u>	7,059	7,059	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,069,678	\$ 6,417,294	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		776,788	13
14	Buildings, at Historical Cost		10,519,965	14
15	Leasehold Improvements, at Historical Cost	874,476	1,416,978	15
16	Equipment, at Historical Cost	1,734,477	2,219,148	16
17	Accumulated Depreciation (book methods)	(1,859,300)	(12,348,680)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		162,166	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(162,166)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	100,000	100,000	22
23	Other(specify): <u>Construction in Progress</u>		11,548	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 849,653	\$ 2,695,747	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,919,331	\$ 9,113,041	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 305,238	\$ 305,238	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	86,625	86,625	28
29	Short-Term Notes Payable	361,016	361,016	29
30	Accrued Salaries Payable	850,061	850,061	30
31	Accrued Taxes Payable (excluding real estate taxes)	27,131	27,131	31
32	Accrued Real Estate Taxes(Sch.IX-B)	520,000	520,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,150,071	\$ 2,150,071	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	110,690	15,000,000	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)	\$ 110,690	\$ 15,000,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,260,761	\$ 17,150,071	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,658,570	\$ (8,037,030)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,919,331	\$ 9,113,041	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,975,286	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,975,286	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	683,284	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)	\$ 683,284	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)	\$ 3,658,570	24 *

* This must agree with page 17, line 47.

XVI. STATEMENT OF CHANGES IN EQUITY

		Total after Consolidation	
1	Balance at Beginning of Year, as Previously Reported	\$ (9,277,061)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (9,277,061)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,640,031	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	(400,000)	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)	\$ 1,240,031	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)	\$ (8,037,030)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Norridge Hlthcr & Rehab Centre# 0032011Report Period Beginning: 1-Jan-2006Ending: 31-Dec-2006**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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 16,871,793	1
2	Discounts and Allowances for all Levels	(3,162,397)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,709,396	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,996,218	6
7	Oxygen	15,793	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,012,011	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	25,297	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	430,527	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	18,697	19
20	Radiology and X-Ray	62,860	20
21	Other Medical Services	138,317	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 675,698	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	***Vending Commissions***	6,000	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,000	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 17,403,105	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,690,983	31
32	Health Care	6,567,696	32
33	General Administration	2,665,722	33
B. Capital Expense			
34	Ownership	3,150,301	34
C. Ancillary Expense			
35	Special Cost Centers	1,472,656	35
36	Provider Participation Fee	172,463	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,719,821	40
41	Income before Income Taxes (line 30 minus line 40)**	683,284	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 683,284	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. *Cash Basis Tax Payer

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Norridge Hlthcr & Rehab Centre

0032011

Report Period Beginning:

1-Jan-2006

Ending:

31-Dec-2006

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	1,925	2,286	\$ 109,241	\$ 47.79	1
2	Assistant Director of Nursing	1,805	2,206	83,586	37.89	2
3	Registered Nurses	85,234	90,432	2,323,886	25.70	3
4	Licensed Practical Nurses	15,804	17,048	448,310	26.30	4
5	CNAs & Orderlies	177,920	191,154	2,055,057	10.75	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,899	2,145	44,603	20.79	9
10	Activity Assistants	10,077	11,281	120,296	10.66	10
11	Social Service Workers	5,399	6,050	91,555	15.13	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	53,312	57,455	620,985	10.81	15
16	Dishwashers					16
17	Maintenance Workers	5,723	6,412	100,314	15.64	17
18	Housekeepers	33,804	37,362	379,551	10.16	18
19	Laundry	18,466	20,518	187,959	9.16	19
20	Administrator	1,893	2,142	93,644	43.72	20
21	Assistant Administrator	1,949	2,099	37,153	17.70	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	21,092	23,083	358,013	15.51	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	17,812	18,778	332,317	17.70	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	454,114	490,451	\$ 7,386,470 *	\$ 15.06	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	712	\$ 21,346	1-3	35
36	Medical Director	1,050	42,000	9-3	36
37	Medical Records Consultant	102	3,637	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	504	7,560	10-3	39
40	Physical Therapy Consultant	249	8,706	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	9	427	11-3	44
45	Social Service Consultant	111	4,226	12-3	45
46	Other(specify)	48	1,399	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,785	\$ 89,301		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	3,301	\$ 96,669	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	3,301	\$ 96,669		53

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	6 Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	Painting & Decorating	Nov-99	\$ 1,966	3	\$ 328	\$	\$	\$	\$	\$	\$	\$	\$
2	Painting & Decorating	Mar-2000	585	3	98								
3	Painting & Decorating	Oct-2000	266	3	45								
4	Painting & Decorating	Nov-2000	50	3	8								
5	Painting & Decorating	Dec-2000	180	3	30								
6	Painting & Decorating	Aug-2001	12,581	3	427	213							
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 15,628		\$ 936	\$ 213	\$	\$	\$	\$	\$	\$	\$

