

Facility Name & ID Number Chicago Ridge Nursing Center

0045815 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 231

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>231</u>	Skilled (SNF)	<u>231</u>	<u>84,315</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>231</u>	TOTALS	<u>231</u>	<u>84,315</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>73,038</u>	<u>1,205</u>	<u>4,521</u>	<u>78,764</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>73,038</u>	<u>1,205</u>	<u>4,521</u>	<u>78,764</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.42%

D. How many bed-hold days during this year were paid by the Department? 2,857 (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)

N/A

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

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

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

I. On what date did you start providing long term care at this location?
Date started 11/01/2001

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 38 and days of care provided 3,965

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	248,991	29,100	8,435	286,526		286,526	16,659	303,185		1
2	Food Purchase		315,287		315,287		315,287	(361)	314,926		2
3	Housekeeping	202,655	22,147		224,802		224,802		224,802		3
4	Laundry	87,544	10,673		98,217		98,217		98,217		4
5	Heat and Other Utilities			228,197	228,197		228,197	2,377	230,574		5
6	Maintenance	28,332	47,441		75,773		75,773	115,428	191,201		6
7	Other (specify):* See Attached Sch			13,197	13,197		13,197		13,197		7
8	TOTAL General Services	567,522	424,648	249,829	1,241,999		1,241,999	134,103	1,376,102		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	2,104,613	64,704	4,335	2,173,652		2,173,652		2,173,652		10
10a	Therapy	16,434		30,634	47,068		47,068		47,068		10a
11	Activities	88,712	815		89,527		89,527		89,527		11
12	Social Services	118,477	44,600	5,770	168,847		168,847		168,847		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,328,236	110,119	40,739	2,479,094		2,479,094		2,479,094		16
	C. General Administration										
17	Administrative	31,211		705,098	736,309		736,309	(322,008)	414,301		17
18	Directors Fees										18
19	Professional Services			54,543	54,543		54,543	5,978	60,521		19
20	Dues, Fees, Subscriptions & Promotions			27,458	27,458		27,458	(10,694)	16,764		20
21	Clerical & General Office Expenses	37,671		96,258	133,929		133,929	89,592	223,521		21
22	Employee Benefits & Payroll Taxes			369,595	369,595		369,595	51,761	421,356		22
23	Inservice Training & Education										23
24	Travel and Seminar			970	970		970	(285)	685		24
25	Other Admin. Staff Transportation							4,157	4,157		25
26	Insurance-Prop.Liab.Malpractice			232,170	232,170		232,170	566	232,736		26
27	Other (specify):* See Attached Sch			660,339	660,339		660,339	(82,839)	577,500		27
28	TOTAL General Administration	68,882		2,146,431	2,215,313		2,215,313	(263,772)	1,951,541		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,964,640	534,767	2,436,999	5,936,406		5,936,406	(129,669)	5,806,737		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 Chicago Ridge Nursing Center

#0045815

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			23,896	23,896		23,896	145,936	169,832			30
31	Amortization of Pre-Op. & Org.							503	503			31
32	Interest			523	523		523	481,340	481,863			32
33	Real Estate Taxes					438,817	438,817		438,817			33
34	Rent-Facility & Grounds			1,871,298	1,871,298	(438,817)	1,432,481	(1,000,000)	432,481			34
35	Rent-Equipment & Vehicles			3,675	3,675		3,675	576	4,251			35
36	Other (specify):*											36
37	TOTAL Ownership			1,899,392	1,899,392		1,899,392	(371,645)	1,527,747			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		217,350	188,381	405,731		405,731		405,731			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			126,473	126,473		126,473		126,473			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		217,350	314,854	532,204		532,204		532,204			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,964,640	752,117	4,651,245	8,368,002		8,368,002	(501,314)	7,866,688			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 **Chicago Ridge Nursing Center**

0045815

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(157)	30		9
10	Interest and Other Investment Income	(28,589)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(361)	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	(43,238)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,200)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(82,839)	27		24
25	Fund Raising, Advertising and Promotional	(8,541)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(9,836)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(181)	20		28
29	Other-Attach Schedule <u>See Attached Schedule</u>	1,243			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (173,699)		\$	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	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)	(327,615)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (327,615)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (501,314)		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

Chicago Ridge Nursing Center

ID# 0045815

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non-Deductible Dues	\$ (2,953)	20	1
2	2008 Seminar	(285)	24	2
3	Franchise Tax From Management Company	(27)	21	3
4	Auto Expense paid by the related entity and			4
5	properly allocated to this facility	3,647	25	5
6	Background Checks paid by the related entity	861	20	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	1,243		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Chicago Ridge Nursing Center# 0045815

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	16,659	0	0	0	0	0	0	0	0	16,659	1
2	Food Purchase	(361)	0	0	0	0	0	0	0	0	0	0	(361)	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	2,377	0	0	0	0	0	0	0	0	0	2,377	5
6	Maintenance	0	1,030	114,398	0	0	0	0	0	0	0	0	115,428	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(361)	3,407	131,057	0	134,103	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	(322,008)	0	0	0	0	0	0	0	0	(322,008)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,200)	0	7,178	0	0	0	0	0	0	0	0	5,978	19
20	Fees, Subscriptions & Promotions	(10,814)	120	0	0	0	0	0	0	0	0	0	(10,694)	20
21	Clerical & General Office Expenses	(43,265)	1,813	131,044	0	0	0	0	0	0	0	0	89,592	21
22	Employee Benefits & Payroll Taxes	0	51,761	0	0	0	0	0	0	0	0	0	51,761	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(285)	0	0	0	0	0	0	0	0	0	0	(285)	24
25	Other Admin. Staff Transportation	3,647	57	453	0	0	0	0	0	0	0	0	4,157	25
26	Insurance-Prop.Liab.Malpractice	0	566	0	0	0	0	0	0	0	0	0	566	26
27	Other (specify):*	(82,839)	0	0	0	0	0	0	0	0	0	0	(82,839)	27
28	TOTAL General Administration	(134,756)	54,317	(183,333)	0	(263,772)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(135,117)	57,724	(52,276)	0	(129,669)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Chicago Ridge Nursing Center# 0045815

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	(157)	0	146,093	0	0	0	0	0	0	0	0	145,936	30
31	Amortization of Pre-Op. & Org.	0	0	503	0	0	0	0	0	0	0	0	503	31
32	Interest	(28,589)	0	509,929	0	0	0	0	0	0	0	0	481,340	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(1,000,000)	0	0	0	0	0	0	0	0	(1,000,000)	34
35	Rent-Equipment & Vehicles	0	576	0	0	0	0	0	0	0	0	0	576	35
36	Other (specify):*	(9,836)	0	9,836	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(38,582)	576	(333,639)	0	(371,645)	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)	(173,699)	58,300	(385,915)	0	(501,314)	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
Marvin Mermelstein	50.00	RREM, Inc. d/b/a Winston Manor Nursing Home	Chicago	Nivram Mng, Inc.	Lincolnwood	Management
Joseph Mermelstein	25.00	Balmoral Home, Inc.	Chicago			
Barry Taerbaum	25.00	Central Home, Inc.	Chicago			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	21 Delivery Expense	\$	Nivram Management, Inc.	50.00%	\$ 351	\$	351	1
2	V	21 Office Expense		Nivram Management, Inc.	50.00%	1,111		1,111	2
3	V	20 Dues & Subscriptions		Nivram Management, Inc.	50.00%	120		120	3
4	V	21 Franchise tax		Nivram Management, Inc.	50.00%	27		27	4
5	V	22 Payroll Taxes		Nivram Management, Inc.	50.00%	49,169		49,169	5
6	V	5 Utilities		Nivram Management, Inc.	50.00%	2,377		2,377	6
7	V	26 Insurance		Nivram Management, Inc.	50.00%	566		566	7
8	V	6 Repairs & Maintenance		Nivram Management, Inc.	50.00%	873		873	8
9	V	22 Health Insurance		Nivram Management, Inc.	50.00%	2,592		2,592	9
10	V	6 Scavenger		Nivram Management, Inc.	50.00%	157		157	10
11	V	35 Rental Equipment		Nivram Management, Inc.	50.00%	576		576	11
12	V	25 Auto Expense		Nivram Management, Inc.	50.00%	57		57	12
13	V	21 Postage		Nivram Management, Inc.	50.00%	324		324	13
14	Total		\$			\$ 58,300	\$ *	58,300	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	19 Legal & Accounting	\$	Nivram Management, Inc.	50.00%	\$ 7,178	\$	7,178	15
16	V	25 Travel		Nivram Management, Inc.	50.00%	453		453	16
17	V	21 Donations		Nivram Management, Inc.	50.00%	120		120	17
18	V	30 Depreciation		Nivram Management, Inc.	50.00%	666		666	18
19	V	21 Data Processing		Nivram Management, Inc.	50.00%	581		581	19
20	V	21 Telephone		Nivram Management, Inc.	50.00%	1,662		1,662	20
21	V	6 Plant Salary		Nivram Management, Inc.	50.00%	31,898		31,898	21
22	V	17 Assistant Administrator Salary		Nivram Management, Inc.	50.00%	47,847		47,847	22
23	V	21 Office Manager Salary		Nivram Management, Inc.	50.00%	19,634		19,634	23
24	V	1 Food Service Supervisor Salary		Nivram Management, Inc.	50.00%	16,659		16,659	24
25	V	17 Administrative Salary		Nivram Management, Inc.	50.00%	71,536		71,536	25
26	V	17 Administrator Salary		Nivram Management, Inc.	50.00%	257,327		257,327	26
27	V	21 Clerical Salaries		Nivram Management, Inc.	50.00%	108,739		108,739	27
28	V	6 Maintenance Salary		Nivram Management, Inc.	50.00%	82,500		82,500	28
29	V	17 Management Fees	698,718	Nivram Management, Inc.	50.00%			(698,718)	29
30	V	34 Rental Income	1,000,000	BM of Chicago Ridge Real Estate, LLC				(1,000,000)	30
31	V	32 Interest Income	1,513	BM of Chicago Ridge Real Estate, LLC				(1,513)	31
32	V	31 Amortization Expense		BM of Chicago Ridge Real Estate, LLC		503		503	32
33	V	21 Bank Charges		BM of Chicago Ridge Real Estate, LLC		58		58	33
34	V	30 Depreciation		BM of Chicago Ridge Real Estate, LLC		145,427		145,427	34
35	V	32 Interest Expense		BM of Chicago Ridge Real Estate, LLC		511,442		511,442	35
36	V	21 Other Taxes		BM of Chicago Ridge Real Estate, LLC		250		250	36
37	V	36 State Income Taxes		BM of Chicago Ridge Real Estate, LLC		9,836		9,836	37
38	V								38
39	Total		\$ 1,700,231			\$ 1,314,316	\$ *	(385,915)	39

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	Henry Mermelstein	Administrator	Administrative	0.00	228,717	7	16.83	Salary	\$ 46,283	17-1	1
2	Louise Mermelstein	Dietary Supervisor	Support	0.00	73,341	7	18.51	Salary	16,659	1-7	2
3	Marvin Mermelstein	Plant Supervisor	Support	50.00	88,102	5	26.58	Salary	31,898	1-7	3
4	Doreen Mermelstein	Office Manager	Administrative	0.00	83,926	8	18.96	Salary	19,634	21-7	4
5											5
6	Marvin Mermelstein	Asst. Administrator	Administrative	See Above	132,153	7	26.58	Salary	47,847	17-7	6
7	Joseph Mermelstein	Owner	Administrative	25.00	69,747	3	26.58	Salary	25,253	17-7	7
8	Barry Taerbaum	Owner	Administrative	25.00	160,026	4	11.00	Salary	150,000	17-7	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 337,574		13

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

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

Facility Name & ID Number Chicago Ridge Nursing Center# 0045815 Report Period Beginning: 01/01/2007 Ending: 2/31/2007

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

Name of Related Organization Nivram Management, Inc.
 Street Address 6500 N. Hamlin Avenue
 City / State / Zip Code Lincolnwood, IL 60712
 Phone Number (847) 679-7484
 Fax Number (847) 679-7494

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	21	Delivery	Resident Beds	869	4	\$ 1,319	\$ 231	\$ 351	1	
2	21	Office Supplies	Resident Beds	869	4	4,179	231	1,111	2	
3	20	Dues & Subscriptions	Resident Beds	869	4	450	231	120	3	
4	21	Franchise Tax	Resident Beds	869	4	100	231	27	4	
5	22	Payroll Taxes	Resident Beds	869	4	184,970	231	49,169	5	
6	5	Utilities	Resident Beds	869	4	8,942	231	2,377	6	
7	26	Insurance	Resident Beds	869	4	2,128	231	566	7	
8	6	Repairs & Maintenance	Resident Beds	869	4	3,286	231	873	8	
9	22	Health Insurance	Resident Beds	869	4	9,750	231	2,592	9	
10	6	Scavenger	Resident Beds	869	4	591	231	157	10	
11	35	Rental Equipment	Resident Beds	869	4	2,167	231	576	11	
12	25	Auto Expense	Resident Beds	869	4	214	231	57	12	
13	21	Postage	Resident Beds	869	4	1,217	231	324	13	
14	19	Legal & Accounting	Resident Beds	869	4	27,004	231	7,178	14	
15	24	Travel	Resident Beds	869	4	1,703	231	453	15	
16	21	Donations	Resident Beds	869	4	450	231	120	16	
17	30	Depreciation	Resident Beds	869	4	2,507	231	666	17	
18	21	Data Processing	Resident Beds	869	4	2,186	231	581	18	
19	21	Telephone	Resident Beds	869	4	6,252	231	1,662	19	
20	6	Plant Salary	Resident Beds	1	1	31,898	31,898	1	31,898	20
21	17	Assistant Administrator Salary	Resident Beds	1	1	47,847	47,847	1	47,847	21
22	21	Office Manager Salary	Resident Beds	1	1	19,634	19,634	1	19,634	22
23	1	Food Service Supervisor Salary	Resident Beds	1	1	16,659	16,659	1	16,659	23
24	17	Administrative Salaries	Resident Beds	1	1	71,536	71,536	1	71,536	24
25	TOTALS					\$ 446,989	\$ 187,574	\$ 256,534	25	

Facility Name & ID Number Chicago Ridge Nursing Center

0045815 Report Period Beginning: 01/01/2007 Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Nivram Management, Inc.
 Street Address 6500 N. Hamlin Avenue
 City / State / Zip Code Lincolnwood, IL 60712
 Phone Number (847) 679-7484
 Fax Number (847) 679-7494

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Administrator Salaries	Direct Cost	1	1	\$ 257,327	\$ 257,327	1	\$ 257,327	1
2	21	Clerical Salaries	Direct Cost	1	1	108,739	108,739	1	108,739	2
3	6	Maintenance Salary	Direct Cost	1	1	82,500	82,500	1	82,500	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					\$ 448,566	\$ 448,566		\$ 448,566	25

Facility Name & ID Number

Chicago Ridge Nursing Center

0045815

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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	Chicago Ridge R/E LP		X	Mortgage	\$80,711.00	7/30/07	\$ 8,884,689	\$ 8,884,689	12/31/08	10.9011	\$ 396,528	1						
2	Parkway Bank & Trust		X	Mortgage	n/a	7/20/07	3,250,000	3,248,925	1/21/08	8.2500	100,942	2						
3	Parkway Bank & Trust		X	Mortgage	n/a	8/13/07	577,500	577,500	04/21/08	7.2500	13,972	3						
4												4						
5												5						
Working Capital																		
6	Parkway Bank & Trust		X	Line of Credit	N/A	01/18/07	195,300	0	08/18/07	7.7500	523	6						
7												7						
8												8						
9	TOTAL Facility Related				\$80,711.00		\$ 12,907,489	\$ 12,711,114			\$ 511,965	9						
B. Non-Facility Related*																		
10	Offset Against Int Inc										(28,589)	10						
11	Offset Against Int Inc										(1,513)	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (30,102)	14						
15	TOTALS (line 9+line14)						\$ 12,907,489	\$ 12,711,114			\$ 481,863	15						

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

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

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

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 2006 report.		\$	28,752	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.)		\$	467,569	2
3. Under or (over) accrual (line 2 minus line 1).		\$	438,817	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		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.		\$	438,817	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	374,839	8
	2003	386,154	9
	2004	399,465	10
	2005	437,990	11
	2006	467,569	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2006	\$	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Chicago Ridge Nursing Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0045815

CONTACT PERSON REGARDING THIS REPORT Sanford B. Alper

TELEPHONE (847) 580-4100 FAX #: (847) 580-4199

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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>24-18-101-025-0000</u>	<u>Nursing Home</u>	\$ <u>342,749.92</u>	\$ <u>342,749.92</u>
2. <u>24-18-101-039-0000</u>	<u>Nursing Home</u>	\$ <u>124,818.86</u>	\$ <u>124,818.86</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>467,568.78</u>	\$ <u>467,568.78</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

Facility Name & ID Number Chicago Ridge Nursing Center

0045815 Report Period Beginning:

01/01/2007 Ending:

12/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 87,480 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3 + Basement

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>73,980</u>	<u>7/31/2007</u>	<u>\$ 425,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	73,980		\$ 425,000	3

Facility Name & ID Number Chicago Ridge Nursing Center

0045815

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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	231		2007		\$ 10,961,027	\$ 114,177	40	\$ 114,177	\$	\$ 113,917	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sign		2001		1,419	36	39	36		222	9
10	Carpet		2002		2,240	58	39	58		317	10
11	Alarm		2002		22,000	564	39	564		3,102	11
12	Washer & Dryer		2002		29,304	751	39	751		4,133	12
13	Phone System		2002		10,667	273	39	273		1,504	13
14	A/C System		2002		11,200	287	39	287		1,580	14
15	Electrical Improvement		2002		3,000	77	39	77		423	15
16	Light Fixtures		2002		10,192	261	39	261		1,437	16
17	RC Alarm		2003		4,500	116	39	116		549	17
18	Water Heater		2003		16,500	423	39	423		2,115	18
19	Boiler		2004		21,500	552	39	552		2,206	19
20	Paving Improvements		2005		21,800	559	39	559		1,677	20
21	Bathroom Improvements		2005		634	16	39	16		48	21
22	Fire Smoke Dampers		2005		3,475	89	39	89		267	22
23	Boiler		2005		11,960	307	39	307		921	23
24	Locks		2006		4,374	112	39	112		224	24
25	Fire Alarm System		2006		98,711	2,531	39	2,531		101,242	25
26	AC Chiller Unit		2006		81,000	2,077	39	2,077		3,115	26
27	Furnace		2007		13,500	317	39	317		317	27
28	Temp Reset Control for Boilers		2007		2,750	59	39	59		59	28
29	Faucets		2007		2,298	49	39	49		49	29
30	Electrical Disconnet for Chiller Unit		2007		8,000	171	39	171		171	30
31	Add'l Amount for '06 AC Chiller Unit		2007		8,000	154	39	154		154	31
32	Hot Water Storage Tank		2007		22,000	329	39	329		329	32
33	Control System for New Chiller		2007		1,191	20	39	20		20	33
34	Grab Bars		2007		4,941	74	39	74		74	34
35	Boiler Room Change-Over Valves		2007		8,380	107	39	107		107	35
36	Water Cooler, attached to Bld		2007		1,087	23	39	23		23	36

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	2007	\$ 3,138	\$ 7	39	\$ 7	\$	\$ 7	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)		\$ 11,390,788	\$ 124,576		\$ 124,576	\$ 240,309	70

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

Facility Name & ID Number Chicago Ridge Nursing Center

0045815

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	\$ 62,113	\$ 10,673	\$ 10,673	\$	10	\$ 36,750	71
72	Current Year Purchases	25,513	2,824	2,551	(273)	10	2,551	72
73	Fully Depreciated Assets							73
74	Mng and Real Estate Co.	750,000	31,916	32,032	116	10	34,454	74
75	TOTALS	\$ 837,626	\$ 45,413	\$ 45,256	\$ (157)		\$ 73,755	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)	\$ 12,653,414	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 169,989	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 169,832	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (157)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 314,064	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: BM of Chicago Ridge Real Estate, L.L.C.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

If NO, see instructions.

	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:	<u>231</u>		\$ <u>1,871,298</u>			3
4	Additions						4
5							5
6							6
7	TOTAL	231		\$ 1,871,298			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: \$ 3,675 Description: 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

10. Effective dates of current rental agreement:

Beginning 08/01/2007

Ending 12/31/2058

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

Fiscal Year Ending Annual Rent

12. 12/31/2008 \$ 2,400,000

13. 12/31/2009 \$ 2,400,000

14. 12/31/2010 \$ 2,400,000

* 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		hrs	\$		\$			\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	39-3	visits			188,381			188,381	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				194,378		194,378	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>See Attached Sch</u>	39-2					22,972		22,972	13
14	TOTAL			\$		\$ 188,381	\$ 217,350		\$ 405,731	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 Chicago Ridge Nursing Center

0045815

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 190,487	\$ 190,833	1
2	Cash-Patient Deposits	33,398	33,398	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,704,206	1,704,206	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	135,984	135,984	6
7	Other Prepaid Expenses	32,556	32,556	7
8	Accounts Receivable (owners or related parties)	4,300	405,638	8
9	Other(specify): <u>Rent Receivable</u>		543,472	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,100,931	\$ 3,046,087	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		425,000	13
14	Buildings, at Historical Cost		10,961,027	14
15	Leasehold Improvements, at Historical Cost	371,999	371,999	15
16	Equipment, at Historical Cost	146,884	896,884	16
17	Accumulated Depreciation (book methods)	(107,086)	(252,513)	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): <u>Loan Costs</u>		87,709	22
23	Other(specify): <u>Refundable Deposit</u>		66,482	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 411,797	\$ 12,556,588	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,512,728	\$ 15,602,675	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 295,066	\$ 295,066	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,606	28,606	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	121,071	121,071	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	2,878,431	2,878,431	36
37	<u>Deferred Income Taxes</u>		8,152	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,323,174	\$ 3,331,326	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,711,114	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Deferred Income Taxes</u>		1,684	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 12,712,798	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,323,174	\$ 16,044,124	46
47	TOTAL EQUITY (page 18, line 24)	\$ (810,446)	\$ (441,449)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,512,728	\$ 15,602,675	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 416,523	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 416,523	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,583,031	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	(2,810,000)	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)	\$ (1,226,969)	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)	\$ (810,446)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Chicago Ridge Nursing Center

0045815

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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	\$ 9,689,375	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,689,375	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	79,658	6
7	Oxygen	51,351	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 131,009	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	10,607	18
19	Laboratory	51,401	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 62,008	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	28,589	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 28,589	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Commissions	4,830	28
28a	See Attached Schedule	35,237	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 40,067	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,951,048	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,241,999	31
32	Health Care	2,479,094	32
33	General Administration	2,215,313	33
	B. Capital Expense		
34	Ownership	1,899,392	34
	C. Ancillary Expense		
35	Special Cost Centers	405,731	35
36	Provider Participation Fee	126,473	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,368,002	40
41	Income before Income Taxes (line 30 minus line 40)**	1,583,046	41
42	Income Taxes	(15)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,583,031	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.

*** 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 Chicago Ridge Nursing Center

0045815

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	2,492	2,652	\$ 82,154	\$ 30.98	1
2	Assistant Director of Nursing	1,214	1,334	30,170	22.62	2
3	Registered Nurses	12,252	12,297	336,771	27.39	3
4	Licensed Practical Nurses	43,169	43,459	920,674	21.18	4
5	CNAs & Orderlies	68,623	71,770	680,792	9.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,890	1,922	16,434	8.55	8
9	Activity Director	2,080	2,120	26,500	12.50	9
10	Activity Assistants	7,302	7,680	62,212	8.10	10
11	Social Service Workers	7,823	8,071	118,477	14.68	11
12	Dietician					12
13	Food Service Supervisor	1,897	1,969	30,520	15.50	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,883	24,767	218,471	8.82	15
16	Dishwashers					16
17	Maintenance Workers	2,431	2,567	28,332	11.04	17
18	Housekeepers	24,170	25,738	202,655	7.87	18
19	Laundry	9,692	10,384	87,544	8.43	19
20	Administrator					20
21	Assistant Administrator	2,080	2,080	31,211	15.01	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,640	4,765	37,671	7.91	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	3,345	3,416	54,052	15.82	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	217,983	226,991	\$ 2,964,640 *	\$ 13.06	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	M	\$ 8,435	1-3	35
36	Medical Director	O			36
37	Medical Records Consultant	N	1,852	10-3	37
38	Nurse Consultant	T			38
39	Pharmacist Consultant	H	2,284	10-3	39
40	Physical Therapy Consultant	L			40
41	Occupational Therapy Consultant	Y			41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	F			43
44	Activity Consultant	E			44
45	Social Service Consultant	E	5,770	12-3	45
46	Other(specify) <u>MDS</u>	S	30,634	10a-3	46
47	<u>Dental Services</u>		199	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 49,174		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Sharon Washington	Assist. Admin	0	\$ 31,211	Workers' Compensation Insurance	\$ 67,736	IDPH License Fee	\$	
				Unemployment Compensation Insurance	53,459	Advertising: Employee Recruitment	8,722	
				FICA Taxes	225,122	Health Care Worker Background Check (Indicate # of checks performed <u>123</u>)	861	
				Employee Health Insurance	19,754	Patient Background Checks <u>138</u>	1,000	
				Employee Meals		See Attached Schedule	14,783	
				Illinois Municipal Retirement Fund (IMRF)*		Allocation from Management Company	120	
				Employees' Physical Exam	3,524			
				Allocation from Management Company	51,761			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 31,211	TOTAL (agree to Schedule V, line 22, col.8)		\$ 421,356		
B. Administrative - Other							Less: Public Relations Expense ()	
Description			Amount				Non-allowable advertising (8,541)	
Management Fees			\$ 705,098				Yellow page advertising (181)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 705,098	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			TOTAL (agree to Sch. V, line 20, col. 8) \$ 16,764	
C. Professional Services							G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
See Attached Schedule			\$ 54,543				Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	685
							Entertainment Expense ()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 54,543	TOTAL			TOTAL (agree to Sch. V, line 24, col. 8) \$ 685	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Chicago Ridge Nursing Center

0045815

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council Long Term Care \$12,509
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A 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. \$ 126,473
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? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A 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. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees