

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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

I. IDPH License ID Number: 0032011

Facility Name: Norridge Healthcare & Rehab Centre

Address: 7001 West Cullom Avenue 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-2007 to 1-Jan-2007 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) _____ 31-March-2008
 (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 Healthcare & Rehab Centre# 0032011 Report Period Beginning: 1-Jan-2007 Ending: 1-Jan-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 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>59,571</u>	<u>8,412</u>	<u>12,974</u>	<u>80,957</u>	8
9	SNF/PED					9
10	ICF	<u>3,397</u>	<u>31</u>		<u>3,428</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>62,968</u>	<u>8,443</u>	<u>12,974</u>	<u>84,385</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.39%

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? 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 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 12,600Medicare 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 2007 Fiscal Year: 31st Dec 2007

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

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-2007 Ending: 1-Jan-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	637,225	52,871	21,567	711,663		711,663	711,663			1
2	Food Purchase		596,710		596,710	(27,747)	568,963	(486)	568,477		2
3	Housekeeping	390,592	116,532		507,124		507,124		507,124		3
4	Laundry	214,084	67,394		281,478		281,478		281,478		4
5	Heat and Other Utilities			369,344	369,344		369,344		369,344		5
6	Maintenance	115,461	203,859	130,689	450,009		450,009		450,009		6
7	Other (specify):*										7
8	TOTAL General Services	1,357,362	1,037,366	521,600	2,916,328	(27,747)	2,888,581	(486)	2,888,095		8
	B. Health Care and Programs										
9	Medical Director			39,750	39,750		39,750		39,750		9
10	Nursing and Medical Records	5,200,129	728,794	89,206	6,018,129		6,018,129		6,018,129		10
10a	Therapy			11,808	11,808		11,808		11,808		10a
11	Activities	147,951	24,905		172,856		172,856		172,856		11
12	Social Services	78,073		4,744	82,817		82,817		82,817		12
13	CNA Training		1,578		1,578		1,578		1,578		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	5,426,153	755,277	145,508	6,326,938		6,326,938		6,326,938		16
	C. General Administration										
17	Administrative	138,193		396,900	535,093		535,093	(192,993)	342,100		17
18	Directors Fees										18
19	Professional Services			68,789	68,789		68,789	12,296	81,085		19
20	Dues, Fees, Subscriptions & Promotions			60,941	60,941		60,941	(38,797)	22,144		20
21	Clerical & General Office Expenses	374,832	59,051	127,443	561,326		561,326	32,027	593,353		21
22	Employee Benefits & Payroll Taxes			1,273,192	1,273,192	27,747	1,300,939	36,201	1,337,140		22
23	Inservice Training & Education			3,869	3,869		3,869	2,872	6,741		23
24	Travel and Seminar			7,142	7,142		7,142	5,942	13,084		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			17,128	17,128		17,128		17,128		26
27	Other (specify):*							28,904	28,904		27
28	TOTAL General Administration	513,025	59,051	1,955,404	2,527,480	27,747	2,555,227	(113,548)	2,441,679		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,296,540	1,851,694	2,622,512	11,770,746		11,770,746	(114,034)	11,656,712		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 Healthcare & Rehab Centre #0032011 Report Period Beginning: 1-Jan-2007 Ending: 1-Jan-2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			125,024	125,024		125,024	201,314	326,338			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							1,464,746	1,464,746			32
33	Real Estate Taxes			506,138	506,138		506,138		506,138			33
34	Rent-Facility & Grounds			2,486,247	2,486,247		2,486,247	(2,484,000)	2,247			34
35	Rent-Equipment & Vehicles			3,759	3,759		3,759		3,759			35
36	Other (specify):*											36
37	TOTAL Ownership			3,121,168	3,121,168		3,121,168	(817,940)	2,303,228			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		286,878	1,007,438	1,294,316		1,294,316		1,294,316			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		286,878	1,179,901	1,466,779		1,466,779		1,466,779			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,296,540	2,138,572	6,923,581	16,358,693		16,358,693	(931,974)	15,426,719			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 Healthcare & Rehab Centre

0032011

Report Period Beginning:

1-Jan-2007

Ending:

1-Jan-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	105,149	30		9
10	Interest and Other Investment Income	(64,085)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(486)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(1,686)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(90,315)	21		24
25	Fund Raising, Advertising and Promotional	(97,554)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,593)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,600)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (156,170)		\$	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)	(775,804)	6 & 6A	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (775,804)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (931,974)		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 Healthcare & Rehab Centre

ID# 0032011

Report Period Beginning: 1-Jan-2007

Ending: 1-Jan-2007

Sch. V Line Reference

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

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

1-Jan-2007

Ending:

1-Jan-2007

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	(486)	0	0	0	0	0	0	0	0	0	0	(486)	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	(486)	0	0	0	0	0	0	0	0	0	0	(486)	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	(192,993)	0	0	0	0	0	0	0	0	0	(192,993)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,296	1,000	0	0	0	0	0	0	0	0	12,296	19
20	Fees, Subscriptions & Promotions	(100,154)	61,357	0	0	0	0	0	0	0	0	0	(38,797)	20
21	Clerical & General Office Expenses	(94,908)	122,342	4,593	0	0	0	0	0	0	0	0	32,027	21
22	Employee Benefits & Payroll Taxes	0	36,201	0	0	0	0	0	0	0	0	0	36,201	22
23	Inservice Training & Education	0	2,872	0	0	0	0	0	0	0	0	0	2,872	23
24	Travel and Seminar	(1,686)	7,628	0	0	0	0	0	0	0	0	0	5,942	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	28,904	0	0	0	0	0	0	0	0	0	28,904	27
28	TOTAL General Administration	(196,748)	77,607	5,593	0	(113,548)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(197,234)	77,607	5,593	0	(114,034)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Norridge Healthcare & Rehab Centre

0032011

Report Period Beginning:

1-Jan-2007 Ending:

1-Jan-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	105,149	1,430	94,735	0	0	0	0	0	0	0	0	201,314	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(64,085)	131,812	1,397,019	0	0	0	0	0	0	0	0	1,464,746	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	41,064	133,242	(992,246)	0	(817,940)	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)	(156,170)	210,849	(986,653)	0	(931,974)	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 Management Fee Income	\$ 396,900	Lancaster, Ltd.	100.00%	\$	\$ (396,900)	1
2	V	17 Officers Salary		Lancaster, Ltd.	100.00%	73,718	73,718	2
3	V	19 Professional Services		Lancaster, Ltd.	100.00%	11,296	11,296	3
4	V	21 Clerical Expenses		Lancaster, Ltd.	100.00%	122,342	122,342	4
5	V	22 Employee Benefits		Lancaster, Ltd.	100.00%	36,201	36,201	5
6	V	24 Seminars & Travel		Lancaster, Ltd.	100.00%	7,628	7,628	6
7	V	17 Adminstrative Consulting		Lancaster, Ltd.	100.00%	130,189	130,189	7
8	V	20 Marketing and Fees		Lancaster, Ltd.	100.00%	59,673	59,673	8
9	V	32 Interest		Lancaster, Ltd.	100.00%	131,812	131,812	9
10	V	30 Depreciation		Lancaster, Ltd.	100.00%	1,430	1,430	10
11	V	20 Dues, Fees and Subscriptions		Lancaster, Ltd.	100.00%	1,684	1,684	11
12	V	27 Payroll Taxes(Staff & Officers)		Lancaster, Ltd.	100.00%	28,904	28,904	12
13	V	23 Education & Inservice		Lancaster, Ltd.	100.00%	2,872	2,872	13
14	Total		\$ 396,900			\$ 607,749	\$ * 210,849	14

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

Facility Name & ID Number Norridge Healthcare & Rehab Centre# 0032011Report Period Beginning: 1-Jan-2007 Ending: 1-Jan-2007**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 Income	\$ 2,484,000				\$ (2,484,000)	15
16	V	32	Interest	102,981			1,500,000	1,397,019	16
17	V	30	Depreciation				94,735	94,735	17
18	V	19	Accounting Fees				1,000	1,000	18
19	V	21	State Replacement Tax				4,593	4,593	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			\$ 2,586,981			\$ 1,600,328	\$ * (986,653)	39

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

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-2007 Ending: 1-Jan-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	Christopher Vicere	VP-Finance	Administrative		See Attached	9	18.75	Lancaster	\$ 36,859	17-7	1
2	Cheryl Morris	VP-Operations	Administrative		See Attached	9	18.75	Lancaster	36,859	17-7	2
3	Sandra Bernett	Administrator								17-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 73,718		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 Healthcare & Rehab Centre

0032011

Report Period Beginning:

1-Jan-2007

Ending: -Jan-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 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	\$ 196,583	\$ 196,583	9	\$ 36,859	1
2	27	Christopher Vicere-payroll tax	Hours Worked	48	7	9,894		9	1,855	2
3	17	Cheryl Morris	Hours Worked	48	7	196,583	196,583	9	36,859	3
4	27	Cheryl Morris-payroll tax	Hours Worked	48	7	9,894		9	1,855	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13	19	Professional Services	Management Fees	1,694,700	7	48,231		396,900	11,296	13
14	21	Clerical Expenses	Management Fees	1,694,700	7	522,379	452,822	396,900	122,342	14
15	22	Employee Benefits	Management Fees	1,694,700	7	154,573		396,900	36,201	15
16	24	Seminars & Travel	Management Fees	1,694,700	7	32,569		396,900	7,628	16
17	17	Administrative Consulting	Management Fees	1,694,700	7	555,885	555,885	396,900	130,189	17
18	20	Marketing and Fees	Management Fees	1,694,700	7	254,796	183,072	396,900	59,673	18
19	32	Interest	Management Fees	1,694,700	7	24,333		396,900	5,699	19
20	30	Depreciation	Management Fees	1,694,700	7	6,106		396,900	1,430	20
21	20	Dues, Fees and Subscriptions	Management Fees	1,694,700	7	7,190		396,900	1,684	21
22	27	Payroll Taxes	Management Fees	1,694,700	7	107,574		396,900	25,194	22
23	23	Education & Inservice	Management Fees	1,694,700	7	12,265		396,900	2,872	23
24	32	*Direct Interest*							126,113	24
25	TOTALS					\$ 2,138,855	\$ 1,584,945		\$ 607,749	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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 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							5,699	6
7	Harston Investments		x	Working Capital							1,500,000	7
8												8
9	TOTAL Facility Related						\$	\$			1,505,699	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$				14
15	TOTALS (line 9+line14)						\$	\$			1,505,699	15

Less: Interest Income (40,953)

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A \$ 1,464,746

* 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.)

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 Norridge Healthcare & Rehab Centre COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0032011

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 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>13-18-318-005-0000</u>	<u>Long-Term Healthcare</u>	\$ <u>126,340.75</u>	\$ <u>126,340.75</u>
2. <u>13-18-318-006-0000</u>	<u>Long-Term Healthcare</u>	\$ <u>126,340.75</u>	\$ <u>126,340.75</u>
3. <u>13-18-318-007-0000</u>	<u>Long-Term Healthcare</u>	\$ <u>127,116.12</u>	\$ <u>127,116.12</u>
4. <u>13-18-318-008-0000</u>	<u>Long-Term Healthcare</u>	\$ <u>126,340.75</u>	\$ <u>126,340.75</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>506,138.37</u>	\$ <u>506,138.37</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 Norridge Healthcare & Rehab Centre

0032011

Report Period Beginning:

1-Jan-2007 Ending:

1-Jan-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	315		1986	1976	\$ 9,204,000	\$	30	\$	\$	\$ 7,194,460	4
5					1,315,965	41,777	30	41,777		654,045	5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1987		43,548	1,382	20	1,644	262	43,213	9
10	Various		1988		3,939	125	20	197	72	4,377	10
11	Various		1988		28,574	459	20	724	265	30,693	11
12	Various		1989		1,297	41	20	65	24	1,281	12
13	Various		1990		3,827	121	20	191	70	3,659	13
14	Various		1990		28,644	909	20	1,433	524	24,639	14
15	Various		1991		72,916	2,314	20	3,650	1,336	59,143	15
16	Various		1992		36,639	1,285	20	1,832	547	29,007	16
17	Various		1993		72,513	1,920	20	3,627	1,707	51,335	17
18	Various		1994		116,353	3,049	20	5,854	2,805	75,680	18
19	Various		1995		95,409	2,447	20	4,770	2,323	59,377	19
20	Boiler/Hot Water Heater Improvements		1996		9,417	241	20	471	230	5,421	20
21	Tuckpointing		1999		28,900	741	20	1,445	704	12,743	21
22	Architect Fee 1st Floor		2001		15,052	386	20	386		2,654	22
23	Construction 1st Floor		2001		166,662	4,273	20	4,273		29,378	23
24	Construction Library		2001		12,461	320	20	320		2,199	24
25	Design Fee-1st Floor		2001		5,130	132	20	132		907	25
26	Sprinklers-1st Floor		2001		4,531	116	20	116		798	26
27	Demolition-1st Floor		2001		5,533	142	20	142		976	27
28	Wooden Doors (2)		2001		1,134	29	20	29		200	28
29	Construction Work		2002		4,207	108	20	108		679	29
30	Smoking Shelter		2002		3,251	83	20	325	242	1,950	30
31	Auto Front Door		2002		2,074	53	20	207	154	1,156	31
32	Fence In Lot		2003		2,972	103	20	198	95	842	32
33	Building New-Town Square		2003		281,539	20,272	20	19,508	(764)	81,283	33
34	Roofing		2003		62,440	1,601	20	6,244	4,643	26,017	34
35	Wanderquard		2004		964		20	96	96	368	35
36	Refuse Inclosure		2004		2,395		20	240		800	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 Healthcare & Rehab Centre

0032011

Report Period Beginning:

1-Jan-2007

Ending:

1-Jan-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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Fire Alarm System	2004	\$ 104,400	\$ 12,027	20	\$ 14,914	\$ 2,887	\$ 55,928	37
38	Patio Concrete	2004	2,500	64	20	250	186	979	38
39	Air Ventilation System	2004	26,794	687	20	2,233	1,546	8,001	39
40	Design & Development of Town Square	2004	42,130	1,080	20	4,213	3,133	16,150	40
41	Consultancy Fire Alarm Installation	2004	22,700	2,615	20	3,243	628	12,161	41
42	Hand Rail System	2005	6,025	154	20	603	449	1,708	42
43	Duct Detectors	2005	2,061	53	20	412	359	1,168	43
44	20 Ton Roof Top Aircon	2005	17,635	452	20	3,527	3,075	9,111	44
45	Elevator Fire Upgrade	2005	46,440	1,191	20	9,288	8,097	23,994	45
46	Concrete Approach Pad	2005	2,160	55	20	216	161	522	46
47	27 Plastic Laminate Doors	2006	6,145	158	20	615	457	1,127	47
48	10 T Rooftop A/C W/Exhaust	2006	24,668	632	20	2,467	1,835	3,906	48
49	Wanderguard	2006	1,000	26	20	100	74	117	49
50	Laminate 2x Egress Doors	2007	4,361	70	20	291	221	291	50
51	Remodel 2ND Floor & Renovate Dementia Unit	2007	447,984	2,397	20	11,200	8,803	11,200	51
52	Cabinetry For 2ND Floor & Dementia Unit	2007	96,950	4,848	20	4,848		4,848	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)		\$ 12,486,239	\$ 110,938		\$ 158,424	\$ 47,246	\$ 8,550,491	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	\$ 865,311	\$ 68,673	\$ 131,041	\$ 62,368	7	\$ 710,275	71
72	Current Year Purchases	220,910	34,738	20,732	(14,006)	7	20,732	72
73	Fully Depreciated Assets	1,353,836	5,411	14,712	9,301	7	1,353,836	73
74	Lancaster Allocation		1,430	1,430		7	13,073	74
75	TOTALS	\$ 2,440,057	\$ 110,252	\$ 167,915	\$ 57,663		\$ 2,097,916	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)	\$ 15,576,296	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 221,190	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 326,339	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 105,149	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 10,648,407	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>2,247</u>			5
6								6
7	TOTAL				\$ <u>2,247</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.	<u> </u> /2008	\$ <u> </u>
13.	<u> </u> /2009	\$ <u> </u>
14.	<u> </u> /2010	\$ <u> </u>

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 @ 313.25 per Month

(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	\$		\$ 408,765	\$		\$ 408,765	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			139,585			139,585	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			459,088			459,088	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	39-3	hrs				8,504		8,504	8
9	Pharmacy	39-2	# of prescrpts				257,190		257,190	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					21,184		21,184	13
14	TOTAL			\$		\$ 1,007,438	\$ 286,878		\$ 1,294,316	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 Healthcare & Rehab Centre# 0032011Report Period Beginning: 1-Jan-2007

Ending:

1-Jan-2007**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 1-Jan-2007

(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	\$ 143,110	\$ 143,110	1
2	Cash-Patient Deposits	92,919	92,919	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	4,437,399	4,437,399	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	97,755	97,755	6
7	Other Prepaid Expenses	200	200	7
8	Accounts Receivable (owners or related parties)		1,610,999	8
9	Other(specify): <u>Employee Advances</u>	7,254	7,254	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,778,637	\$ 6,389,636	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	878,836	1,966,272	15
16	Equipment, at Historical Cost	1,898,901	2,440,058	16
17	Accumulated Depreciation (book methods)	(1,984,324)	(12,568,439)	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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 893,413	\$ 3,234,644	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,672,050	\$ 9,624,280	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 362,254	\$ 423,431	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	95,431	95,431	28
29	Short-Term Notes Payable	568,848	568,848	29
30	Accrued Salaries Payable	898,124	898,124	30
31	Accrued Taxes Payable (excluding real estate taxes)	30,621	30,621	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)	\$ 2,475,278	\$ 2,536,455	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		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)	\$	\$ 15,000,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,475,278	\$ 17,536,455	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,196,772	\$ (7,912,175)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,672,050	\$ 9,624,280	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,658,570	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,658,570	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(461,798)	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)	\$ (461,798)	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)	\$ 3,196,772	24 *

* This must agree with page 17, line 47.

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (8,037,030)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (8,037,030)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	524,855	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)	\$ 124,855	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)	\$ (7,912,175)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Norridge Healthcare & Rehab Centre

0032011

Report Period Beginning: 1-Jan-2007

Ending: 1-Jan-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	\$ 15,404,320	1
2	Discounts and Allowances for all Levels	(2,696,250)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,708,070	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,539,839	6
7	Oxygen	2,172	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,542,011	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	443,736	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,563	19
20	Radiology and X-Ray	30,485	20
21	Other Medical Services	86,932	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 576,716	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	64,085	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 64,085	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Vending Commissions</u>	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)	\$ 15,896,882	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,916,328	31
32	Health Care	6,326,938	32
33	General Administration	2,527,467	33
B. Capital Expense			
34	Ownership	3,121,168	34
C. Ancillary Expense			
35	Special Cost Centers	1,294,316	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)*	\$ 16,358,680	40
41	Income before Income Taxes (line 30 minus line 40)**	(461,798)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (461,798)	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 Taxpayer

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. **Offset pg 5 & 9**

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

Facility Name & ID Number Norridge Healthcare & Rehab Centre

0032011

Report Period Beginning:

1-Jan-2007

Ending:

1-Jan-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	1,785	2,201	\$ 89,805	\$ 40.80	1
2	Assistant Director of Nursing	1,917	2,236	75,941	33.96	2
3	Registered Nurses	89,170	96,613	2,534,766	26.24	3
4	Licensed Practical Nurses	8,962	9,549	248,889	26.06	4
5	CNAs & Orderlies	176,292	191,216	2,028,831	10.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,962	2,213	45,693	20.65	9
10	Activity Assistants	9,221	10,072	102,258	10.15	10
11	Social Service Workers	4,593	5,155	78,073	15.15	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	52,883	57,834	637,225	11.02	15
16	Dishwashers					16
17	Maintenance Workers	4,834	5,403	115,461	21.37	17
18	Housekeepers	35,328	38,846	390,592	10.05	18
19	Laundry	20,672	22,789	214,084	9.39	19
20	Administrator	1,696	1,819	78,552	43.18	20
21	Assistant Administrator	2,178	2,515	59,641	23.71	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,625	22,860	374,832	16.40	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	12,229	13,795	221,897	16.09	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	444,347	485,116	\$ 7,296,540 *	\$ 15.04	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	719	\$ 21,567	1-3	35
36	Medical Director	994	39,750	9-3	36
37	Medical Records Consultant	113	4,037	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	294	4,410	10-3	39
40	Physical Therapy Consultant	337	11,808	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	125	4,744	12-3	45
46	Other(specify) <u>Dementia Consult</u>	119	3,463	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,701	\$ 89,779		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,640	\$ 77,296	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,640	\$ 77,296		53

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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	
Sandra Bernett	Administrator	N/A	\$ 78,552	Workers' Compensation Insurance	\$ 195,051	IDPH License Fee	\$ 995	
Barbara Dabrowski	Asst.Administrator	N/A	59,641	Unemployment Compensation Insurance	84,448	Advertising: Employee Recruitment	10,381	
				FICA Taxes	547,228	Health Care Worker Background Check		
				Employee Health Insurance	339,479	(Indicate # of checks performed <u>80</u>)	800	
				Employee Meals	27,747	Patient Background Checks	320 3,200	
				Illinois Municipal Retirement Fund (IMRF)*		***Promotional Advertising***	38,797	
				Uniforms	3,187	***Dues & Subscriptions***	1,260	
				Retirement Plan Contributions	67,670	***Licenses & Fees***	5,279	
				Misc. Employment Benefits	35,281	***Related Parties Allocation***	61,357	
				Employment Fees	848	***Contributions***	229	
				Lancaster Allocation	36,201	Less: Public Relations Expense	(61,357)	
						Non-allowable advertising	(36,197)	
						Yellow page advertising	(2,600)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 138,193	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 1,337,140		\$ 22,144		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
Description			Amount	Description	Line #	Amount	G. Schedule of Travel and Seminar**	
Management Fees-Lancaster, Ltd.			\$ 396,900				Description	Amount
							Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 396,900					
							Seminar Expense	7,142
							Lancaster Allocation	7,628
							Entertainment Expense	(1,686)
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 68,789	TOTAL		\$	TOTAL	\$ 13,084

* Attach copy of IMRF notifications

**See instructions.

