

Facility Name & ID Number Chicago Ridge Nursing Center

0045815 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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>84,546</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>84,546</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>74,617</u>	<u>1,008</u>	<u>3,551</u>	<u>79,176</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>74,617</u>	<u>1,008</u>	<u>3,551</u>	<u>79,176</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.65%

D. How many bed-hold days during this year were paid by the Department? 2,385 (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 11/01/01 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 2,974

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	263,191	24,416	11,117	298,724		298,724	18,325	317,049		1
2	Food Purchase		338,497		338,497		338,497	(341)	338,156		2
3	Housekeeping	201,993	29,010		231,003		231,003		231,003		3
4	Laundry	95,156	12,407		107,563		107,563		107,563		4
5	Heat and Other Utilities			246,336	246,336		246,336	4,145	250,481		5
6	Maintenance	27,753	34,693		62,446		62,446	130,358	192,804		6
7	Other (specify):* Schedule Attached			18,751	18,751		18,751		18,751		7
8	TOTAL General Services	588,093	439,023	276,204	1,303,320		1,303,320	152,487	1,455,807		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	2,018,682	84,386	43,687	2,146,755		2,146,755		2,146,755		10
10a	Therapy	17,597			17,597		17,597		17,597		10a
11	Activities	104,864	412		105,276		105,276		105,276		11
12	Social Services	133,319	34,200	5,525	173,044		173,044		173,044		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,274,462	118,998	49,212	2,442,672		2,442,672		2,442,672		16
	C. General Administration										
17	Administrative	29,600		662,468	692,068		692,068	(295,519)	396,549		17
18	Directors Fees										18
19	Professional Services			73,518	73,518		73,518	12,010	85,528		19
20	Dues, Fees, Subscriptions & Promotions			32,847	32,847	1,000	33,847	(8,018)	25,829		20
21	Clerical & General Office Expenses	53,225		36,445	89,670	(1,000)	88,670	96,159	184,829		21
22	Employee Benefits & Payroll Taxes			357,621	357,621		357,621	38,153	395,774		22
23	Inservice Training & Education										23
24	Travel and Seminar			965	965		965	285	1,250		24
25	Other Admin. Staff Transportation			40	40		40	49	89		25
26	Insurance-Prop.Liab.Malpractice			108,093	108,093		108,093	206,502	314,595		26
27	Other (specify):* Bad Debts			61,707	61,707		61,707	(61,707)			27
28	TOTAL General Administration	82,825		1,333,704	1,416,529		1,416,529	(12,086)	1,404,443		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,945,380	558,021	1,659,120	5,162,521		5,162,521	140,401	5,302,922		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:

01/01/2008

Ending:

12/31/2008

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			24,115	24,115		24,115	435,831	459,946			30
31	Amortization of Pre-Op. & Org.							5,539	5,539			31
32	Interest							816,190	816,190			32
33	Real Estate Taxes							504,597	504,597			33
34	Rent-Facility & Grounds			2,437,152	2,437,152		2,437,152	(1,715,403)	721,749			34
35	Rent-Equipment & Vehicles			2,790	2,790		2,790	1,030	3,820			35
36	Other (specify):*											36
37	TOTAL Ownership			2,464,057	2,464,057		2,464,057	47,784	2,511,841			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		247,369	141,864	389,233		389,233		389,233			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			126,820	126,820		126,820		126,820			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		247,369	268,684	516,053		516,053		516,053			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,945,380	805,390	4,391,861	8,142,631		8,142,631	188,185	8,330,816			45

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

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	3,724	30		9
10	Interest and Other Investment Income	(46,482)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(341)	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	(14)	21		18
19	Entertainment				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	(61,707)	27		24
25	Fund Raising, Advertising and Promotional	(1,035)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(35)	20		28
29	Other-Attach Schedule	(6,294)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (112,184)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	300,369		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 300,369		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 188,185		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						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: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non Deductible Dues	\$ (8,601)	20	1
2	2008 Seminar Paid for in 2007	285	24	2
3	Franchise Tax from Management Company	(27)	21	3
4	Copier Payments Paid by Balmoral Home, Inc.	558	35	4
5	Employee Background Checks paid by Balmoral Home	1,001	20	5
6	Resident Background Checks paid by Affiliated Co.	490	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	(6,294)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Chicago Ridge Nursing Center# 0045815

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	18,325	0	0	0	0	0	0	0	0	18,325	1
2	Food Purchase	(341)	0	0	0	0	0	0	0	0	0	0	(341)	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	4,145	0	0	0	0	0	0	0	0	0	4,145	5
6	Maintenance	0	2,078	128,280	0	0	0	0	0	0	0	0	130,358	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(341)	6,223	146,605	0	152,487	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	(295,519)	0	0	0	0	0	0	0	0	(295,519)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	12,010	0	0	0	0	0	0	0	0	12,010	19
20	Fees, Subscriptions & Promotions	(8,180)	122	40	0	0	0	0	0	0	0	0	(8,018)	20
21	Clerical & General Office Expenses	(41)	2,315	93,885	0	0	0	0	0	0	0	0	96,159	21
22	Employee Benefits & Payroll Taxes	0	38,153	0	0	0	0	0	0	0	0	0	38,153	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	0	49	0	0	0	0	0	0	0	0	0	49	25
26	Insurance-Prop.Liab.Malpractice	0	464	206,038	0	0	0	0	0	0	0	0	206,502	26
27	Other (specify):*	(61,707)	0	0	0	0	0	0	0	0	0	0	(61,707)	27
28	TOTAL General Administration	(69,643)	41,103	16,454	0	(12,086)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(69,984)	47,326	163,059	0	140,401	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Chicago Ridge Nursing Center

0045815

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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 TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	3,724	0	432,107	0	0	0	0	0	0	0	0	435,831	30
31	Amortization of Pre-Op. & Org.	0	0	5,539	0	0	0	0	0	0	0	0	5,539	31
32	Interest	(46,482)	0	862,672	0	0	0	0	0	0	0	0	816,190	32
33	Real Estate Taxes	0	0	504,597	0	0	0	0	0	0	0	0	504,597	33
34	Rent-Facility & Grounds	0	0	(1,715,403)	0	0	0	0	0	0	0	0	(1,715,403)	34
35	Rent-Equipment & Vehicles	558	472	0	0	0	0	0	0	0	0	0	1,030	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(42,200)	472	89,512	0	47,784	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)	(112,184)	47,798	252,571	0	188,185	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 Mngmt, Inc.	Lincolnwood	Management
Joseph Mermelstein Trust	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: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	21 Delivery Expense	\$	Nivram Management, Inc.	50.00%	\$ 586	\$	586	1
2	V	21 Office Expenses		Nivram Management, Inc.	50.00%	1,135		1,135	2
3	V	20 Dues & Subscriptions		Nivram Management, Inc.	50.00%	122		122	3
4	V	21 Franchise Tax		Nivram Management, Inc.	50.00%	27		27	4
5	V	22 Payroll Taxes		Nivram Management, Inc.	50.00%	34,833		34,833	5
6	V	5 Utilities		Nivram Management, Inc.	50.00%	4,145		4,145	6
7	V	26 Insurance		Nivram Management, Inc.	50.00%	464		464	7
8	V	6 Repaire & Maintenance		Nivram Management, Inc.	50.00%	1,935		1,935	8
9	V	22 Health Insurance		Nivram Management, Inc.	50.00%	3,320		3,320	9
10	V	6 Scavenger		Nivram Management, Inc.	50.00%	143		143	10
11	V	35 Equipment Rental		Nivram Management, Inc.	50.00%	472		472	11
12	V	25 Auto Expense		Nivram Management, Inc.	50.00%	49		49	12
13	V	21 Postage		Nivram Management, Inc.	50.00%	567		567	13
14	Total		\$			\$	\$ *	47,798	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%	\$ 6,380	\$	6,380	15
16	V	20 Licenses & Permits		Nivram Management, Inc.	50.00%	40		40	16
17	V	30 Depreciation		Nivram Management, Inc.	50.00%	198		198	17
18	V	19 Data Processing		Nivram Management, Inc.	50.00%	630		630	18
19	V	21 Telephone		Nivram Management, Inc.	50.00%	2,068		2,068	19
20	V	6 Plant Salary		Nivram Management, Inc.	50.00%	35,088		35,088	20
21	V	17 Assistant Administrator Salary		Nivram Management, Inc.	50.00%	52,631		52,631	21
22	V	21 Office Manager Salary		Nivram Management, Inc.	50.00%	21,595		21,595	22
23	V	1 Food Service Supervisor Salary		Nivram Management, Inc.	50.00%	18,325		18,325	23
24	V	17 Administrative Salaries		Nivram Management, Inc.	50.00%	78,689		78,689	24
25	V	17 Administrator Salaries		Nivram Management, Inc.	50.00%	235,629		235,629	25
26	V	21 Clerical Salaries		Nivram Management, Inc.	50.00%	70,207		70,207	26
27	V	6 Maintenance Salary		Nivram Management, Inc.	50.00%	93,192		93,192	27
28	V	17 Management Fees		Nivram Management, Inc.	50.00%			(662,468)	28
29	V	34 Rental Income		BM of Chicago Ridge Real Estate, LLC				(1,715,403)	29
30	V	32 Interest Income		BM of Chicago Ridge Real Estate, LLC				(2,139)	30
31	V	31 Amortization Expense		BM of Chicago Ridge Real Estate, LLC		5,539		5,539	31
32	V	21 Bank Charges		BM of Chicago Ridge Real Estate, LLC		15		15	32
33	V	30 Depreciation		BM of Chicago Ridge Real Estate, LLC		431,909		431,909	33
34	V	26 Insurance		BM of Chicago Ridge Real Estate, LLC		206,038		206,038	34
35	V	32 Interest Expense		BM of Chicago Ridge Real Estate, LLC		864,811		864,811	35
36	V	19 Other Professional Services		BM of Chicago Ridge Real Estate, LLC		5,000		5,000	36
37	V	33 Real Estate Taxes		BM of Chicago Ridge Real Estate, LLC		504,597		504,597	37
38	V								38
39	Total		\$			\$ 2,632,581	\$ *	252,571	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: 01/01/2008 Ending: 12/31/2008

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	251,589	7	17.50	Salary	\$ 50,911	17-7	1
2	Louise Mermelstein	Dietary Supervisor	Support	0.00	80,675	7	17.50	Salary	18,325	1-7	2
3	Marvin Mermelstein	Plant Supervisor	Support	50.00	96,912	5	27.78	Salary	35,088	6-7	3
4	Doreen Mermelstein	Office Manager	Administrative	0.00	92,305	8	20.00	Salary	21,595	21-7	4
5											5
6	Marvin Mermelstein	Asst. Administrator	Administrative	See Above	145,369	7	25.93	Salary	52,631	17-7	6
7	Joseph Mermelstein	Owner	Administrative	25.00	76,722	3	25.00	Salary	27,778	17-7	7
8	Barry Taerbaum	Administrator	Administrative	25.00	119,936	20	50.00	Salary	119,937	17-7	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 326,265		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: 01/01/2008 Ending: 2/31/2008

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	21	Delivery Expense	Resident Beds	869	4	\$ 2,205	\$ 231	\$ 586	1	
2	21	Office Expenses	Resident Beds	869	4	4,269	231	1,135	2	
3	20	Dues & Subscriptions	Resident Beds	869	4	460	231	122	3	
4	21	Franchise Tax	Resident Beds	869	4	100	231	27	4	
5	22	Payroll Taxes	Resident Beds	869	4	131,039	231	34,833	5	
6	5	Utilities	Resident Beds	869	4	15,594	231	4,145	6	
7	26	Insurance	Resident Beds	869	4	1,745	231	464	7	
8	6	Repairs & Maintenance	Resident Beds	869	4	7,278	231	1,935	8	
9	22	Health Insurance	Resident Beds	869	4	12,490	231	3,320	9	
10	6	Scavenger	Resident Beds	869	4	538	231	143	10	
11	35	Equipment Rental	Resident Beds	869	4	1,777	231	472	11	
12	25	Auto Expense	Resident Beds	869	4	183	231	49	12	
13	21	Postage	Resident Beds	869	4	2,133	231	567	13	
14	19	Legal & Accounting	Resident Beds	869	4	24,000	231	6,380	14	
15	20	Licenses & Permits	Resident Beds	869	4	150	231	40	15	
16	30	Depreciation	Resident Beds	869	4	743	231	198	16	
17	19	Data Processing	Resident Beds	869	4	2,369	231	630	17	
18	21	Telephone	Resident Beds	869	4	7,780	231	2,068	18	
19	6	Plant Salary	Direct Cost	1	1	35,088	35,088	1	35,088	19
20	17	Assistant Administrator Salary	Direct Cost	1	1	52,631	52,631	1	52,631	20
21	21	Office Manager Salary	Direct Cost	1	1	21,595	21,595	1	21,595	21
22	1	Food Service Supersisor Salary	Direct Cost	1	1	18,325	18,325	1	18,325	22
23	17	Administrative Salaries	Direct Cost	1	1	78,689	78,689	1	78,689	23
24	17	Administrator Salaries	Direct Cost	1	1	235,629	235,629	1	235,629	24
25	TOTALS					\$ 656,810	\$ 441,957	\$ 499,071	25	

Facility Name & ID Number Chicago Ridge Nursing Center

0045815

Report Period Beginning:

01/01/2008

Ending: 2/31/2008

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	21	Clerical Salaries	Direct Cost	1	\$ 70,207	\$ 70,207	1	\$ 70,207	1
2	6	Maintenance Salary	Direct Cost	1	93,192	93,192	1	93,192	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 163,399	\$ 163,399		\$ 163,399	25

Facility Name & ID Number

Chicago Ridge Nursing Center

0045815

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Deutsche Bank Mortgage, Inc.		X	Mortgage	\$134,314.00	02/07/08	\$ 13,345,000	\$ 13,260,544	03/01/2043	6.0800	\$ 725,860	1								
2	Chicago Ridge Real Estate LP		X	Bridge Loan from Seller	Interest Only	07/30/07	8,884,689		12/01/2008	10.4266	100,833	2								
3												3								
4												4								
5												5								
Working Capital																				
6	Parkway Bank & Trust Co		X	Fund Purchase of real estate	Interest Only	07/20/07	3,250,000		01/21/2008	8.2500	32,788	6								
7	Parkway Bank & Trust Co		X	Rollover of previous loan	Interest Only	01/21/08	577,500		04/21/2008	7.2500	5,330	7								
8												8								
9	TOTAL Facility Related				\$134,314.00		\$ 26,057,189	\$ 13,260,544			\$ 864,811	9								
B. Non-Facility Related*																				
10	Offset Against Int Income										(2,139)	10								
11	Offset Against Int Income										(46,482)	11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (48,621)	14								
15	TOTALS (line 9+line14)						\$ 26,057,189	\$ 13,260,544			\$ 816,190	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 119,828 Line # 26

* 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 2007 report.

\$ **489,900** 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.)

\$ **489,900** 2

3. Under or (over) accrual (line 2 minus line 1).

\$ 3

4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ **504,597** 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.

\$ **504,597** 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	386,154	8
	2004	399,465	9
	2005	437,990	10
	2006	467,569	11
	2007	489,900	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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>359,120.03</u>	\$ <u>359,120.03</u>
2. <u>24-18-101-039-0000</u>	<u>Nursing Home</u>	\$ <u>130,780.38</u>	\$ <u>130,780.38</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>489,900.41</u>	\$ <u>489,900.41</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

01/01/2008 Ending:

12/31/2008

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>\$ 435,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	73,980		\$ 435,000	3

Facility Name & ID Number Chicago Ridge Nursing Center

0045815

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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		\$ 9,936,943	\$ 255,500	20-40	\$ 255,500	\$	\$ 361,959	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sign		2001		1,419	36	39	36		259	9
10	Carpet		2002		2,240	58	39	58		376	10
11	Alarm		2002		22,000	564	39	564		3,502	11
12	Washer & Dryer		2002		29,304	752	39	752		5,166	12
13	Phone System		2002		10,667	273	39	273		1,652	13
14	A/C System		2002		11,200	287	39	287		1,735	14
15	Electrical Improvement		2002		3,000	77	39	77		465	15
16	Light Fixtures		2002		10,192	261	39	261		1,579	16
17	RC Alarm		2003		4,500	115	39	115		663	17
18	Water Heater		2003		16,500	1,580	5	1,650	70	16,500	18
19	Boiler		2004		21,500	551	39	551		2,205	19
20	Paving Improvements		2005		21,800	1,453	39	1,453		5,329	20
21	Bathroom Improvements		2005		634	17	39	17		56	21
22	Fire Smoke Dampers		2005		3,475	89	39	89		349	22
23	Boiler		2005		11,960	1,636	5	2,392	756	9,506	23
24	Locks		2006		4,374	112	39	112		234	24
25	Fire Alarm System		2006		98,711	2,531	39	2,531		5,273	25
26	AC Chiller Unit		2006		81,000	2,077	39	2,077		5,885	26
27	Furnace		2007		13,500	346	39	346		663	27
28	Temp Reset Control for Boilers		2007		2,750	70	39	70		129	28
29	Faucets		2007		2,298	59	39	59		108	29
30	Electrical Disconnect for Chiller Unit		2007		8,000	205	39	205		376	30
31	Add'l Amount for '06 AC Chiller Unit		2007		8,000	205	39	205		359	31
32	Hot Water Storage Tank		2007		22,000	564	39	564		893	32
33	Control System for New Chiller		2007		1,191	31	39	31		51	33
34	Grab Bars		2007		4,941	127	39	127		201	34
35	Boiler Room Change-Over Valves		2007		8,380	215	39	215		322	35
36	Water Cooler, attached to Bldg		2007		1,087	28	39	28		51	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	\$ 80	39	\$ 80	\$	\$ 87	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)		\$ 10,366,704	\$ 269,899		\$ 270,725	\$ 826	\$ 425,933	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:

01/01/2008

Ending:

12/31/2008

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	\$ 42,785	\$ 7,565	\$ 9,408	\$ 1,843	5	\$ 20,474	71
72	Current Year Purchases	4,121	417	417		5	417	72
73	Fully Depreciated Assets	46,336	1,735	2,206	471	5-7	46,336	73
74	Management & Real Estate Co	1,764,084	176,606	177,190	584		249,912	74
75	TOTALS	\$ 1,857,326	\$ 186,323	\$ 189,221	\$ 2,898		\$ 317,139	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)	\$ 12,659,030	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 456,222	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 459,946	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,724	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 743,072	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: _____

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:	<u>231</u>		\$ <u>2,437,152</u>			3
4	Additions						4
5							5
6							6
7	TOTAL	231		\$ 2,437,152			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: \$ 3,820 Description: Copiers

(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 01/01/2008

Ending 12/31/2008

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

Fiscal Year Ending Annual Rent

12. /2009 \$ 1,860,000

13. /2010 \$ 1,860,000

14. /2011 \$ 1,860,000

* 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	39-3	hrs			141,864			141,864	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				236,670		236,670	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>Schedule Attached</u>						10,699		10,699	13
14	TOTAL			\$		\$ 141,864	\$ 247,369		\$ 389,233	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: 01/01/2008

Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(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	\$ 200,183	\$ 204,932	1
2	Cash-Patient Deposits	79,074	79,074	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,987,326	2,987,326	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	58,603	159,691	6
7	Other Prepaid Expenses	20,733	20,983	7
8	Accounts Receivable (owners or related parties)	2,314	2,314	8
9	Other(specify): <u>Escrow Accounts</u>		745,190	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,348,233	\$ 4,199,510	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		435,000	13
14	Buildings, at Historical Cost		9,936,942	14
15	Leasehold Improvements, at Historical Cost	371,999	371,999	15
16	Equipment, at Historical Cost	151,005	1,915,089	16
17	Accumulated Depreciation (book methods)	(131,201)	(743,072)	17
18	Deferred Charges		200,172	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 391,803	\$ 12,116,130	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,740,036	\$ 16,315,640	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 592,283	\$ 592,283	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	55,030	55,030	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	130,895	130,895	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		67,187	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Schedule Attached</u>	3,579,012	3,043,626	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,357,220	\$ 3,889,021	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		13,260,543	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)	\$	\$ 13,260,543	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,357,220	\$ 17,149,564	46
47	TOTAL EQUITY(page 18, line 24)	\$ (617,184)	\$ (833,924)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,740,036	\$ 16,315,640	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (810,446)	1
2	Restatements (describe):		2
3	Rounding	(5)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (810,451)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,163,267	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	(1,970,000)	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)	\$ 193,267	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)	\$ (617,184)	24 *

* This must agree with page 17, line 47.

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	\$ 10,110,985	1
2	Discounts and Allowances for all Levels	(2,381)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,108,604	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	71,795	6
7	Oxygen	43,653	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 115,448	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	3,409	18
19	Laboratory	7,225	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 10,634	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	46,482	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 46,482	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Commission	4,440	28
28a	Miscellaneous Income	20,290	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 24,730	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,305,898	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,303,320	31
32	Health Care	2,442,672	32
33	General Administration	1,416,529	33
	B. Capital Expense		
34	Ownership	2,464,057	34
	C. Ancillary Expense		
35	Special Cost Centers	389,233	35
36	Provider Participation Fee	126,820	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,142,631	40
41	Income before Income Taxes (line 30 minus line 40)**	2,163,267	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,163,267	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:

01/01/2008

Ending:

12/31/2008

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	2,546	2,690	\$ 86,019	\$ 31.98	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,988	8,076	220,219	27.27	3
4	Licensed Practical Nurses	48,558	48,731	1,050,917	21.57	4
5	CNAs & Orderlies	64,433	67,222	648,157	9.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,829	1,953	17,597	9.01	8
9	Activity Director	2,012	2,052	26,680	13.00	9
10	Activity Assistants	7,568	8,094	78,184	9.66	10
11	Social Service Workers	7,773	8,185	133,319	16.29	11
12	Dietician					12
13	Food Service Supervisor	2,680	2,773	39,950	14.41	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,546	24,508	223,241	9.11	15
16	Dishwashers					16
17	Maintenance Workers	2,347	2,523	27,753	11.00	17
18	Housekeepers	23,404	24,704	201,993	8.18	18
19	Laundry	10,416	11,661	95,156	8.16	19
20	Administrator					20
21	Assistant Administrator	1,840	2,000	29,600	14.80	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,462	6,694	53,225	7.95	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,341	1,422	13,370	9.40	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	213,743	223,288	\$ 2,945,380 *	\$ 13.19	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	\$ 11,117	1-3	35
36	Medical Director	O			36
37	Medical Records Consultant	N	1,840	10-3	37
38	Nurse Consultant	T			38
39	Pharmacist Consultant	H			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	5,525	12-3	45
46	Other(specify)	S			46
47	MDS Care Consultant		41,847	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 60,329		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	Asst Admin	0	\$ 29,600	Workers' Compensation Insurance	\$ 68,734	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance	40,866	Advertising: Employee Recruitment	5,338		
				FICA Taxes	223,519	Health Care Worker Background Check			
				Employee Health Insurance	24,111	(Indicate # of checks performed (143)	1,001		
				Employee Meals	0	Patient Background Checks	149		
				Illinois Municipal Retirement Fund (IMRF)*		Schedule Attached	15,848		
				Employee Physical Exams	391	Advertising - Non-patient related	1,035		
				Allocation from Management Company	38,153	Yellow Page Advertising	35		
						Allocation from Management Company	162		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 29,600			Less: Public Relations Expense	()		
						Non-allowable advertising	(1,035)		
						Yellow page advertising	(35)		
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 25,829		
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)					
Description			Amount						
Management Fees			\$ 662,468						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 662,468	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description			Description		
Vendor/Payee	Type		Amount		Line #	Amount		Amount	
Schedule Attached			\$ 73,518				Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense	1,250	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 73,518	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 1,250

* Attach copy of IMRF notifications

**See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2005	FY2006	FY2007	FY2008
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								

Facility Name & ID Number Chicago Ridge Nursing Center

0045815

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

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 \$16,459
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 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. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 126,820
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. \$ N/A Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 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? N/A
g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A 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