

Facility Name & ID Number Norridge Hlthcr & Rehab Centre# 0032011 Report Period Beginning: 1-Jan-2008 Ending: 31-Dec-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 Jan 1st 2008

	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>303</u>	<u>110,898</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>105</u>	Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>315</u>	TOTALS	<u>303</u>	<u>110,898</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>52,717</u>	<u>9,455</u>	<u>17,697</u>	<u>79,869</u>	8
9	SNF/PED					9
10	ICF	<u>6,647</u>	<u>893</u>	<u>76</u>	<u>7,616</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>59,364</u>	<u>10,348</u>	<u>17,773</u>	<u>87,485</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.89%

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 303 and days of care provided 17,058Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 31-Dec-2008 Fiscal Year: 31-Dec-2008

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

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-2008 Ending: 31-Dec-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	691,868	62,269	22,122	776,259		776,259		776,259			1
2	Food Purchase		648,212		648,212	(29,514)	618,698	(449)	618,249			2
3	Housekeeping	472,401	139,501		611,902		611,902		611,902			3
4	Laundry	217,967	58,719		276,686		276,686		276,686			4
5	Heat and Other Utilities			414,546	414,546		414,546		414,546			5
6	Maintenance	56,925	122,745	151,144	330,814		330,814	15,470	346,284			6
7	Other (specify):*											7
8	TOTAL General Services	1,439,161	1,031,446	587,812	3,058,419	(29,514)	3,028,905	15,021	3,043,926			8
	B. Health Care and Programs											
9	Medical Director			37,500	37,500		37,500		37,500			9
10	Nursing and Medical Records	5,599,423	722,030	101,014	6,422,467		6,422,467		6,422,467			10
10a	Therapy		32,273	23,183	55,456		55,456		55,456			10a
11	Activities	176,635	42,146		218,781		218,781		218,781			11
12	Social Services	117,331		4,732	122,063		122,063		122,063			12
13	CNA Training		260	2,300	2,560		2,560		2,560			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,893,389	796,709	168,729	6,858,827		6,858,827		6,858,827			16
	C. General Administration											
17	Administrative	137,697		396,900	534,597		534,597	(197,962)	336,635			17
18	Directors Fees											18
19	Professional Services			57,469	57,469		57,469	11,184	68,653			19
20	Dues, Fees, Subscriptions & Promotions			64,163	64,163		64,163	(29,096)	35,067			20
21	Clerical & General Office Expenses	433,699	76,380	358,475	868,554		868,554	(155,514)	713,040			21
22	Employee Benefits & Payroll Taxes			1,367,543	1,367,543	29,514	1,397,057	27,709	1,424,766			22
23	Inservice Training & Education			780	780		780	378	1,158			23
24	Travel and Seminar			8,211	8,211		8,211	755	8,966			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			201,175	201,175		201,175		201,175			26
27	Other (specify):* *Payroll Taxes (Sch. VII)**							32,893	32,893			27
28	TOTAL General Administration	571,396	76,380	2,454,716	3,102,492	29,514	3,132,006	(309,653)	2,822,353			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,903,946	1,904,535	3,211,257	13,019,738		13,019,738	(294,632)	12,725,106			29

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

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

Facility Name & ID Number Norridge Hlthcr & Rehab Centre

#0032011

Report Period Beginning: 1-Jan-2008 Ending:

31-Dec-2008

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			271,602	271,602	271,602	123,238	394,840				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						1,496,149	1,496,149				32
33	Real Estate Taxes			560,993	560,993	560,993		560,993				33
34	Rent-Facility & Grounds			2,487,128	2,487,128	2,487,128	(2,484,000)	3,128				34
35	Rent-Equipment & Vehicles			2,510	2,510	2,510		2,510				35
36	Other (specify):*											36
37	TOTAL Ownership			3,322,233	3,322,233	3,322,233	(864,613)	2,457,620				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		693,777	1,278,468	1,972,245	1,972,245		1,972,245				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			166,347	166,347	166,347		166,347				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		693,777	1,444,815	2,138,592	2,138,592		2,138,592				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,903,946	2,598,312	7,978,305	18,480,563	18,480,563	(1,159,245)	17,321,318				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	(43,453)	30		9
10	Interest and Other Investment Income	(8,236)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(449)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(100)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(310,274)	21		24
25	Fund Raising, Advertising and Promotional	(106,314)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,867)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,892)	20		28
29	Other-Attach Schedule	(644)	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (477,229)		\$	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)	(682,016)	6&6A	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (682,016)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (1,159,245)		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			\$		38
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47			\$		47

BHF USE ONLY					
48		49		50	51
					52

Norridge Hlther & Rehab Centre

ID# 0032011

Report Period Beginning: 1-Jan-2008

Ending: 31-Dec-2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Painting & Decorating incurred in 2008	\$ (900)	6 1
2	Painting & Decorating allocated for 2008	256	6 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	(644)	49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

1-Jan-2008

Ending:

31-Dec-2008**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	(449)	0	0	0	0	0	0	0	0	0	0	(449)	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	(644)	8,114	8,000	0	0	0	0	0	0	0	0	15,470	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,093)	8,114	8,000	0	15,021	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	(197,962)	0	0	0	0	0	0	0	0	0	(197,962)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	10,184	1,000	0	0	0	0	0	0	0	0	11,184	19
20	Fees, Subscriptions & Promotions	(109,306)	80,210	0	0	0	0	0	0	0	0	0	(29,096)	20
21	Clerical & General Office Expenses	(315,141)	154,760	4,867	0	0	0	0	0	0	0	0	(155,514)	21
22	Employee Benefits & Payroll Taxes	0	27,709	0	0	0	0	0	0	0	0	0	27,709	22
23	Inservice Training & Education	0	378	0	0	0	0	0	0	0	0	0	378	23
24	Travel and Seminar	0	755	0	0	0	0	0	0	0	0	0	755	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	32,893	0	0	0	0	0	0	0	0	0	32,893	27
28	TOTAL General Administration	(424,447)	108,927	5,867	0	(309,653)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(425,540)	117,041	13,867	0	(294,632)	29							

STATE OF ILLINOIS

Facility Name & ID Number Norridge Hlthcr & Rehab Centre

0032011 Report Period Beginning:

1-Jan-2008 Ending:

Summary B
31-Dec-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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(43,453)	14,826	151,865	0	0	0	0	0	0	0	0	123,238	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,236)	60,091	1,444,294	0	0	0	0	0	0	0	0	1,496,149	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	(51,689)	74,917	(887,841)	0	(864,613)	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)	(477,229)	191,958	(873,974)	0	(1,159,245)	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' Salaries		Lancaster,Ltd.	100.00%	64,570	64,570	2
3	V	27 Payroll Taxes-Officers & Staff		Lancaster,Ltd.	100.00%	32,893	32,893	3
4	V	19 Professional Services		Lancaster,Ltd.	100.00%	10,184	10,184	4
5	V	21 Clerical Expenses		Lancaster,Ltd.	100.00%	154,760	154,760	5
6	V	22 Employee Benefits		Lancaster,Ltd.	100.00%	27,709	27,709	6
7	V	24 Seminars and Travel		Lancaster,Ltd.	100.00%	755	755	7
8	V	6 Repairs and Maintenance		Lancaster,Ltd.	100.00%	8,114	8,114	8
9	V	17 Administrative Consulting		Lancaster,Ltd.	100.00%	134,368	134,368	9
10	V	32 Interest including Direct Interest		Lancaster,Ltd.	100.00%	60,091	60,091	10
11	V	30 Depreciation		Lancaster,Ltd.	100.00%	14,826	14,826	11
12	V	20 Dues, Fees and Sub/Marketing Fees		Lancaster,Ltd.	100.00%	80,210	80,210	12
13	V	23 Education & Inservice		Lancaster,Ltd.	100.00%	378	378	13
14	Total		\$ 396,900			\$ 588,858	\$ * 191,958	14

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

Facility Name & ID Number Norridge Hlthcr & Rehab Centre# 0032011Report Period Beginning: 1-Jan-2008 Ending: 31-Dec-2008

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	Norridge Associates		\$	(2,484,000)	15
16	V	32 Interest	55,706	Norridge Associates		1,500,000	1,444,294	16
17	V	30 Depreciation		Norridge Associates		151,865	151,865	17
18	V	19 Accounting Fees		Norridge Associates		1,000	1,000	18
19	V	6 Repairs and Maintenance		Norridge Associates		8,000	8,000	19
20	V	21 State Replacement Tax		Norridge Associates		4,867	4,867	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		\$ 2,539,706			\$ 1,665,732	\$ * (873,974)	39

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

Facility Name & ID Number Norridge Hlthcr & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-2008 Ending: 31-Dec-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	Christopher Vicere	VP-Finance	Administrative		See Attached	9	18.75	Lancaster	\$ 32,285	17-7	1
2	Cheryl Morris	VP-Operations	Administrative		See Attached	9	18.75	Lancaster	32,285	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 64,570		13

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

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

Facility Name & ID Number Norridge Hlthcr & Rehab Centre

0032011

Report Period Beginning:

1-Jan-2008

Ending: -Dec-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 Lancaster, Ltd.
 Street Address 5061 N Pulaski Road
 City / State / Zip Code Chicago, IL 60630
 Phone Number (773) 6044416
 Fax Number (773) 478-1192

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Christopher Vicere	Hours Worked	48	7	\$ 172,189	\$ 172,189	9	\$ 32,285	1
2	27	Christopher Vicere-payroll tax	Hours Worked	48	7	9,309		9	1,745	2
3	17	Cheryl Morris	Hours Worked	48	7	172,189	172,189	9	32,285	3
4	27	Cheryl Morris-payroll tax	Hours Worked	48	7	9,309		9	1,745	4
5										5
6										6
7										7
8										8
9										9
10	19	Professional Services	Management Fees	1,694,700	7	43,482		396,900	10,184	10
11	21	Clerical Expenses	Management Fees	1,694,700	7	660,800	590,769	396,900	154,760	11
12	22	Employee Benefits	Management Fees	1,694,700	7	118,314		396,900	27,709	12
13	24	Seminars and Travel	Management Fees	1,694,700	7	3,223		396,900	755	13
14	17	Administrative Consulting	Management Fees	1,694,700	7	573,729	573,729	396,900	134,368	14
15	20	Marketing Fees	Management Fees	1,694,700	7	336,332	316,659	396,900	78,769	15
16	30	Depreciation	Management Fees	1,694,700	7	63,305		396,900	14,826	16
17	20	Dues, Fees and Subscriptions	Management Fees	1,694,700	7	6,153		396,900	1,441	17
18	27	Payroll Taxes	Management Fees	1,694,700	7	125,546		396,900	29,403	18
19	23	Education and Inservice	Management Fees	1,694,700	7	1,615		396,900	378	19
20	32	*Direct Interest*	Management Fees	1,694,700	7			396,900	60,091	20
21	6	Repairs and Maintenance	Management Fees	1,694,700	7	34,646		396,900	8,114	21
22										22
23										23
24										24
25	TOTALS					\$ 2,330,141	\$ 1,825,535		\$ 588,858	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

Set Off Interest Income (3,851.00)

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

1,496,149

Pg 4 Line 32 Col.8

* 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

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																																
1. Real Estate Tax accrual used on 2007 report.		\$ 520,000	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.)		\$ 535,993	2																													
3. Under or (over) accrual (line 2 minus line 1).		\$ 15,993	3																													
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 545,000	4																													
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																													
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																													
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 560,993	7																													
Real Estate Tax History:																																
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2003</td><td>464,854</td><td>8</td></tr> <tr><td>2004</td><td>496,535</td><td>9</td></tr> <tr><td>2005</td><td>509,988</td><td>10</td></tr> <tr><td>2006</td><td>506,138</td><td>11</td></tr> <tr><td>2007</td><td>535,993</td><td>12</td></tr> </table>	2003	464,854	8	2004	496,535	9	2005	509,988	10	2006	506,138	11	2007	535,993	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2007 \$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr> </table>	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
2003	464,854	8																														
2004	496,535	9																														
2005	509,988	10																														
2006	506,138	11																														
2007	535,993	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																														
Accrual is based on weighted average of last 4 year's taxes																																

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 Norridge Hlther & 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 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>13-18-318-005-0000</u>	<u>Long-Term Healthcare</u>	\$ <u>133,796.49</u>	\$ <u>133,796.49</u>
2. <u>13-18-318-006-0000</u>	<u>Long-Term Healthcare</u>	\$ <u>133,796.49</u>	\$ <u>133,796.49</u>
3. <u>13-18-318-007-0000</u>	<u>Long-Term Healthcare</u>	\$ <u>134,603.84</u>	\$ <u>134,603.84</u>
4. <u>13-18-318-008-0000</u>	<u>Long-Term Healthcare</u>	\$ <u>133,796.49</u>	\$ <u>133,796.49</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>535,993.31</u>	\$ <u>535,993.31</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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 89,972 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

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

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

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

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

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

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			1886	\$ 650,000	1
2					2
3	TOTALS			\$ 650,000	3

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

Report Period Beginning:

1-Jan-2008 Ending: 31-Dec-2008

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1986	1976	\$ 9,204,000	\$	30	\$	\$	\$ 7,194,460	4
5					1,315,965	41,777	30	41,777		695,822	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	43,548	1,382	20	335	(1,047)	43,548	9
10	Various			1988	3,939	125	20		(125)	3,939	10
11	Various			1988	28,574	459	20		(459)	28,574	11
12	Various			1989	1,297	41	20	16	(25)	1,297	12
13	Various			1990	3,827	121	20	168	47	3,827	13
14	Various			1990	28,644	909	20	1,711	802	26,788	14
15	Various			1991	72,916	2,314	20	3,650	1,336	63,912	15
16	Various			1992	36,639	950	20	1,497	547	31,504	16
17	Various			1993	72,513	1,920	20	3,627	1,707	54,962	17
18	Various			1994	116,353	3,049	20	5,854	2,805	81,534	18
19	Various			1995	95,409	2,447	20	4,770	2,323	64,147	19
20	Boiler/Hot Water Heater Improvements			1996	9,417	241	20	471	230	5,892	20
21	Tuckpointing			1999	28,900	741	20	1,445	704	14,188	21
22	Architect Fee 1st Floor			2001	15,052	386	20	386		3,040	22
23	Construction 1st Floor			2001	166,662	4,273	20	4,273		33,651	23
24	Construction Library			2001	12,461	320	20	320		2,519	24
25	Design Fee-1st Floor			2001	5,130	132	20	132		1,039	25
26	Sprinklers-1st Floor			2001	4,531	116	20	116		914	26
27	Demolition-1st Floor			2001	5,533	142	20	142		1,118	27
28	Wooden Doors (2)			2001	1,134	29	20	29		229	28
29	Construction Work			2002	4,207	108	20	108		787	29
30	Smoking Shelter			2002	3,251	83	20	325	242	2,275	30
31	Auto Front Door			2002	2,074	53	20	207	154	1,363	31
32	Fence In Lot			2003	2,972	93	20	198	105	1,040	32
33	Building New-Town Square			2003	281,539	18,243	20	19,508	1,265	100,791	33
34	Roofing			2003	62,440	1,601	20	6,244	4,643	32,261	34
35	Wanderguard			2004	964		20	96	96	464	35
36	Refuse Inclosure			2004	2,395		20	240	240	1,040	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Norridge Hlthcr & Rehab Centre

0032011

Report Period Beginning:

1-Jan-2008

Ending:

31-Dec-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	
	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	\$ 70,842	37
38	Patio Concrete	2004	2,500	64	20	250	186	1,229	38
39	Air Ventilation System	2004	26,794	687	20	2,233	1,546	10,234	39
40	Design & Development of Town Square	2004	42,130	1,080	20	4,213	3,133	20,363	40
41	Consultancy Fire Alarm Installation	2004	22,700	2,615	20	3,243	628	15,404	41
42	Hand Rail System	2005	6,025	154	20	603	449	2,311	42
43	Duct Detectors	2005	2,061	53	20	412	359	1,580	43
44	20 ton Roof Top Aircon	2005	17,635	452	20	3,527	3,075	12,638	44
45	Elevator Fire Upgrade	2005	46,440	1,191	20	9,288	8,097	33,282	45
46	Concrete Approach Pad	2005	2,160	55	20	216	161	738	46
47	27 Plastic Laminate Doors	2006	6,145	158	20	615	457	1,742	47
48	10T Rooftop A/C W/Exhaust	2006	24,668	632	20	2,467	1,835	6,373	48
49	Wanderguard	2006	1,000	26	20	100	74	217	49
50	Laminate 2x Egress Doors	2007	4,361	112	20	436	324	727	50
51	Electrical Fittings, Fixtures & Holders 2nd Floor	2007	6,512	167	20	651	484	814	51
52	Construction Cost-2nd Floor & Dementia Unit	2007	294,274	7,546	20	29,427	21,881	36,784	52
53	Architectural Cost-2nd Floor & Dementia Unit	2007	13,657	350	20	1,366	1,016	1,707	53
54	Wallcoverings, Borders, Accent Tiles, Murals-2ND Floor	2007	41,777	1,071	20	4,178	3,107	5,223	54
55	Fixtures & Fittings Incl.countertops,Sinks & Blinds	2007	56,845	1,457	20	5,684	4,227	7,105	55
56	Glazed/Unglazed Vinyl/Ceramic Tiles & Floor Coverings	2007	34,919	895	20	3,492	2,597	4,365	56
57	Cabinetry For 2nd Floor & Dementia Unit	2007	96,950	36,841	20	19,390	(17,451)	24,238	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	\$ 149,688		\$ 204,350	\$ 54,662	\$ 8,754,841	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	\$ 684,743	\$ 103,979	\$ 113,108	\$ 9,129	7	\$ 472,504	71
72	Current Year Purchases	260,549	156,329	32,688	(123,641)	7	32,688	72
73	Fully Depreciated Assets	1,755,314	13,470	29,867	16,397	7	1,755,314	73
74	Lancaster Allocation		14,826	14,826			27,899	74
75	TOTALS	\$ 2,700,606	\$ 288,604	\$ 190,489	\$ (98,115)		\$ 2,288,405	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)	\$ 15,836,845	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 438,292	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 394,839	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (43,453)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 11,043,246	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: **Norridge Associates - A related entity**

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>3,128</u>			5
6								6
7	TOTAL				\$ <u>3,128</u>			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: \$ 2,510 Description: Minolta Copier @ 209.17 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

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>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</u>	\$ _____

* 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 checked="" type="checkbox"/> YES <input 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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>96</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>48</u></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	60	200		260
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		2,300		2,300
9	TOTALS	\$ 60	\$ 2,500	\$	\$ 2,560
10	SUM OF line 9, col. 1 and 2 (e)	\$ 2,560			

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	42
2. From other facilities (f)	10
DROP-OUTS	
1. From this facility	15
2. From other facilities (f)	5
TOTAL TRAINED	72

- (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	\$		\$ 492,000	\$		\$ 492,000	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			152,418			152,418	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			634,050			634,050	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	39-2	hrs				2,377		2,377	8
9	Pharmacy	39-2	# of prescrpts				557,678		557,678	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>*Medical Supplies*</u>	39-2					77,818		77,818	12
13	Other (specify): <u>*Bed Rental*</u>	39-2					55,904		55,904	13
14	TOTAL			\$		\$ 1,278,468	\$ 693,777		\$ 1,972,245	14

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

Facility Name & ID Number Norridge Hlthcr & Rehab Centre# 0032011Report Period Beginning: 1-Jan-2008

Ending:

31-Dec-2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 31-Dec-2008 (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	\$ 68,221	\$ 68,221	1
2	Cash-Patient Deposits	86,511	86,511	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	5,251,529	5,251,529	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	80,687	80,687	6
7	Other Prepaid Expenses	7,878	7,878	7
8	Accounts Receivable (owners or related parties)		1,604,578	8
9	Other(specify): <u>Employee Advances</u>	6,529	6,529	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,501,355	\$ 7,105,933	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	2,159,451	2,700,608	16
17	Accumulated Depreciation (book methods)	(2,255,926)	(12,991,906)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		165,278	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(165,278)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>**Goodwill**</u>	100,000	100,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 882,361	\$ 3,071,727	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,383,716	\$ 10,177,660	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 601,109	\$ 601,109	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	104,256	104,256	28
29	Short-Term Notes Payable	1,124,190	403,106	29
30	Accrued Salaries Payable	599,958	599,958	30
31	Accrued Taxes Payable (excluding real estate taxes)	90,337	90,337	31
32	Accrued Real Estate Taxes(Sch.IX-B)	545,000	545,000	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)	\$ 3,064,850	\$ 2,343,766	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)	\$ 3,064,850	\$ 17,343,766	46
47	TOTAL EQUITY (page 18, line 24)	\$ 3,318,866	\$ (7,166,106)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,383,716	\$ 10,177,660	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,584,027	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,584,027	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	122,086	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) **Treasury stock**	(387,247)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (265,161)	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)	\$ 3,318,866	24 *

* This must agree with page 17, line 47.

XVI. STATEMENT OF CHANGES IN EQUITY

		Total after consolidation	
1	Balance at Beginning of Year, as Previously Reported	\$ (7,524,919)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (7,524,919)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	996,060	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	(250,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Treasury stock**	(387,247)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 358,813	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)	\$ (7,166,106)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Norridge Hlthcr & Rehab Centre

0032011

Report Period Beginning: 1-Jan-2008

Ending: 31-Dec-2008

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	\$ 20,818,915	1
2	Discounts and Allowances for all Levels	(6,295,281)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 14,523,634	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,120,116	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,120,116	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	58,175	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	635,386	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	21,233	19
20	Radiology and X-Ray	89,871	20
21	Other Medical Services	139,998	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 944,663	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	8,236	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,236	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)	\$ 18,602,649	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	3,058,419	31
32	Health Care	6,858,827	32
33	General Administration	3,102,492	33
B. Capital Expense			
34	Ownership	3,322,233	34
C. Ancillary Expense			
35	Special Cost Centers	1,972,245	35
36	Provider Participation Fee	166,347	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 18,480,563	40
41	Income before Income Taxes (line 30 minus line 40)**	122,086	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 122,086	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 Hlthcr & Rehab Centre

0032011

Report Period Beginning:

1-Jan-2008

Ending:

31-Dec-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	1,658	1,918	\$ 82,247	\$ 42.88	1
2	Assistant Director of Nursing	4,976	5,703	199,705	35.02	2
3	Registered Nurses	83,084	89,338	2,378,212	26.62	3
4	Licensed Practical Nurses	15,751	16,190	404,742	25.00	4
5	CNAs & Orderlies	204,664	219,764	2,341,086	10.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,002	2,189	46,842	21.40	9
10	Activity Assistants	12,256	12,840	129,793	10.11	10
11	Social Service Workers	7,602	8,295	117,331	14.14	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	55,602	60,956	691,868	11.35	15
16	Dishwashers					16
17	Maintenance Workers	4,042	4,436	56,925	12.83	17
18	Housekeepers	37,777	41,468	472,401	11.39	18
19	Laundry	20,821	22,745	217,967	9.58	19
20	Administrator	751	899	98,000	109.01	20
21	Assistant Administrator	3,077	3,342	39,697	11.88	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	23,582	26,003	433,699	16.68	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	10,273	11,681	193,431	16.56	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	487,918	527,767	\$ 7,903,946 *	\$ 14.98	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	737	\$ 22,122	1-3	35
36	Medical Director	936	37,500	9-3	36
37	Medical Records Consultant	73	3,600	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	927	23,183	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	124	4,732	12-3	45
46	Other(specify) <u>Dementia</u>	105	3,045	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,902	\$ 94,182		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	3,702	\$ 94,369	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	3,702	\$ 94,369		53

Facility Name & ID Number Norridge Hlthcr & Rehab Centre

0032011

Report Period Beginning: 1-Jan-2008

Ending: 31-Dec-2008

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		
Safet Keljalic	Administrator	N/A	\$ 98,000	Workers' Compensation Insurance	\$ 149,106	IDPH License Fee	\$ 1,999		
Barbara Dabrowski	Asst.Administrator	N/A	39,697	Unemployment Compensation Insurance	75,204	Advertising: Employee Recruitment	14,324		
				FICA Taxes	598,293	Health Care Worker Background Check			
				Employee Health Insurance	396,121	(Indicate # of checks performed <u>227</u>)	3,632		
				Employee Meals	29,514	Patient Background Checks <u>210</u>	3,360		
				Illinois Municipal Retirement Fund (IMRF)*		***Promotional Advertising***	28,996		
				Employment Fees	480	***Contributions***	100		
				Misc. Employment Benefits	31,273	***Dues & Subscriptions***	209		
				Uniforms	6,476	***Licenses & Fees***	11,543		
				Retirement Plan Contributions	110,590	***Related Parties Allocation***	80,210		
				***Lancaster Allocation**	27,709	Less: Public Relations Expense	(80,210)		
						Non-allowable advertising	(26,204)		
						Yellow page advertising	(2,892)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 137,697	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)			
				\$ 1,424,766		\$ 35,067			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Management Fees-Lancaster,Ltd			\$ 396,900				Out-of-State Travel	\$	
							In-State Travel	2,468	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 396,900				Seminar Expense	5,743	
							Lancaster Allocation	755	
C. Professional Services									
Vendor/Payee	Type		Amount				Entertainment Expense	()	
Personnel Planners, Inc	Payroll Tax Consultant		\$ 1,868				(agree to Sch. V, line 24, col. 8)		
Frost, Ruttenberg & Rothblatt	Accounting		1,525						
Richard Peelo & Assoc., Inc	Accounting		2,250						
Stone, Pogrund & Korey	Legal		4,399						
Childress, Duffy Goltblatt	Legal		8,365						
Myers, Miller & Krauskopf	Legal		5,776						
Law Office of Carter Korey	Legal		5,175						
Cook County Sheriff Office	Legal		15,000						
Medifax-EDI	Data Processing		2,030						
Accu-Med	Data Processing		3,885						
HealthData Systems	Data Processing		6,461						
AT & T Internet Services	Data Processing		735						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 57,469	TOTAL		\$	TOTAL		

* 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 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1	Painting & Decorating	Aug-2001	\$ 12,581	3	\$	\$	\$	\$	\$	\$	\$	\$	\$
2	Painting & Decorating	July-2007	320	3			54	106	106	54			
3	Painting & Decorating	2008	900	3				150	300	300	150		
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 13,801		\$	\$	\$ 54	\$ 256	\$ 406	\$ 354	\$ 150	\$	\$

