



Facility Name & ID Number Chicago Ridge Nursing Center

# 0045815 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

**III. STATISTICAL DATA**

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 231

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>231</u>	Skilled (SNF)	<u>231</u>	<u>84,315</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>231</u>	TOTALS	<u>231</u>	<u>84,315</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	<u>72,895</u>	<u>1,956</u>	<u>5,047</u>	<u>79,898</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>72,895</u>	<u>1,956</u>	<u>5,047</u>	<u>79,898</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.76%

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

2,633 (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 11/01/2001 NO

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

YES  NO  If YES, enter number of beds certified 38 and days of care provided 4,387

Medicare Intermediary National Government Services

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

**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
	<b>A. General Services</b>										
1	Dietary	274,331	23,901	8,758	306,990		306,990	36,000	342,990		1
2	Food Purchase		313,082		313,082		313,082	(774)	312,308		2
3	Housekeeping	237,443	28,397		265,840		265,840		265,840		3
4	Laundry	86,870	7,024		93,894		93,894		93,894		4
5	Heat and Other Utilities			205,674	205,674		205,674	2,734	208,408		5
6	Maintenance	28,198	48,028		76,226		76,226	131,563	207,789		6
7	Other (specify):* <a href="#">Attached Schedule</a>			18,920	18,920		18,920	170	19,090		7
8	<b>TOTAL General Services</b>	626,842	420,432	233,352	1,280,626		1,280,626	169,693	1,450,319		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	1,848,494	77,250	246,508	2,172,252		2,172,252		2,172,252		10
10a	Therapy										10a
11	Activities	82,332	647		82,979		82,979		82,979		11
12	Social Services	130,028	42,972	4,832	177,832		177,832		177,832		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,060,854	120,869	251,340	2,433,063		2,433,063		2,433,063		16
	<b>C. General Administration</b>										
17	Administrative	50,144		896,409	946,553		946,553	(346,613)	599,940		17
18	Directors Fees										18
19	Professional Services			61,614	61,614		61,614	9,997	71,611		19
20	Dues, Fees, Subscriptions & Promotions			29,196	29,196		29,196	(10,788)	18,408		20
21	Clerical & General Office Expenses	56,204		38,893	95,097		95,097	119,362	214,459		21
22	Employee Benefits & Payroll Taxes			306,110	306,110		306,110	37,769	343,879		22
23	Inservice Training & Education										23
24	Travel and Seminar			600	600		600		600		24
25	Other Admin. Staff Transportation			80	80		80	28	108		25
26	Insurance-Prop.Liab.Malpractice							239,107	239,107		26
27	Other (specify):* <a href="#">Bad Debt Expense</a>			53,148	53,148		53,148	(53,148)			27
28	<b>TOTAL General Administration</b>	106,348		1,386,050	1,492,398		1,492,398	(4,286)	1,488,112		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,794,044	541,301	1,870,742	5,206,087		5,206,087	165,407	5,371,494		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:

01/01/2009

Ending:

12/31/2009

## 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	
	<b>D. Ownership</b>											
30	Depreciation			21,633	21,633		21,633	435,248	456,881			30
31	Amortization of Pre-Op. & Org.							5,873	5,873			31
32	Interest			38,016	38,016		38,016	677,029	715,045			32
33	Real Estate Taxes							666,091	666,091			33
34	Rent-Facility & Grounds			1,860,000	1,860,000		1,860,000	(1,860,000)				34
35	Rent-Equipment & Vehicles			440	440		440	550	990			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,920,089	1,920,089		1,920,089	(75,209)	1,844,880			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		235,133	266,534	501,667		501,667		501,667			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			126,473	126,473		126,473		126,473			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		235,133	393,007	628,140		628,140		628,140			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,794,044	776,434	4,183,838	7,754,316		7,754,316	90,198	7,844,514			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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	2,045	30		9
10	Interest and Other Investment Income	(83,514)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(774)	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	(17)	21		18
19	Entertainment				19
20	Contributions	(500)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(736)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(53,148)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(6,000)	20		28
29	Other-Attach Schedule	(5,500)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (148,144)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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)			34
35	Other- Attach Schedule	238,342		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 238,342		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 90,198		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

<b>BHF USE ONLY</b>							
48		49		50		51	52

Chicago Ridge Nursing Center

ID# 0045815

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Franchise Tax from Management Company	\$ (29)	21	1
2	Sales Taxes from Management Company	(388)	2	2
3	Non Deductible Dues	(7,217)	20	3
4	Background Checks paid by Affiliated Companies	2,134	20	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	<b>Total</b>	(5,500)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Chicago Ridge Nursing Center# 0045815

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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	36,000	0	0	0	0	0	0	0	0	36,000	1
2	Food Purchase	(1,162)	388	0	0	0	0	0	0	0	0	0	(774)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	2,734	0	0	0	0	0	0	0	0	0	2,734	5
6	Maintenance	0	1,935	129,628	0	0	0	0	0	0	0	0	131,563	6
7	Other (specify):*	0	170	0	0	0	0	0	0	0	0	0	170	7
8	<b>TOTAL General Services</b>	<b>(1,162)</b>	<b>5,227</b>	<b>165,628</b>	<b>0</b>	<b>169,693</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	(346,613)	0	0	0	0	0	0	0	0	(346,613)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(736)	0	10,733	0	0	0	0	0	0	0	0	9,997	19
20	Fees, Subscriptions & Promotions	(11,083)	140	155	0	0	0	0	0	0	0	0	(10,788)	20
21	Clerical & General Office Expenses	(546)	1,658	118,250	0	0	0	0	0	0	0	0	119,362	21
22	Employee Benefits & Payroll Taxes	0	37,769	0	0	0	0	0	0	0	0	0	37,769	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	28	0	0	0	0	0	0	0	0	28	25
26	Insurance-Prop.Liab.Malpractice	0	1,563	237,544	0	0	0	0	0	0	0	0	239,107	26
27	Other (specify):*	(53,148)	0	0	0	0	0	0	0	0	0	0	(53,148)	27
28	<b>TOTAL General Administration</b>	<b>(65,513)</b>	<b>41,130</b>	<b>20,097</b>	<b>0</b>	<b>(4,286)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(66,675)</b>	<b>46,357</b>	<b>185,725</b>	<b>0</b>	<b>165,407</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Chicago Ridge Nursing Center# 0045815

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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	2,045	0	433,203	0	0	0	0	0	0	0	0	435,248	30
31	Amortization of Pre-Op. & Org.	0	0	0	5,873	0	0	0	0	0	0	0	5,873	31
32	Interest	(83,514)	65	760,478	0	0	0	0	0	0	0	0	677,029	32
33	Real Estate Taxes	0	0	666,091	0	0	0	0	0	0	0	0	666,091	33
34	Rent-Facility & Grounds	0	0	(1,860,000)	0	0	0	0	0	0	0	0	(1,860,000)	34
35	Rent-Equipment & Vehicles	0	550	0	0	0	0	0	0	0	0	0	550	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(81,469)</b>	<b>615</b>	<b>(228)</b>	<b>5,873</b>	<b>0</b>	<b>(75,209)</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(148,144)</b>	<b>46,972</b>	<b>185,497</b>	<b>5,873</b>	<b>0</b>	<b>90,198</b>	<b>45</b>						

**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	40.10	RREM, Inc. d/b/a Winston Manor Nursing Home	Chicago	Nivram Mngmt, Inc.	Lincolnwood	Management
Joseph Mermelstein	15.10	Balmoral Home, Inc.	Chicago			
Barry Taerbaum	25.00	Central Home, Inc.	Chicago			
Marvin Mermelstein Family Trust	9.90					
Joseph A. Mermelstein Family Trust	9.90					

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	21 Delivery Expense	\$	Nivram Management, Inc.	50.00%	\$ 178	\$	178	1
2	V	21 Office Expense		Nivram Management, Inc.	50.00%	1,451		1,451	2
3	V	20 Dues & Subscriptions		Nivram Management, Inc.	50.00%	140		140	3
4	V	21 Franchise Tax		Nivram Management, Inc.	50.00%	29		29	4
5	V	32 Interest Expense		Nivram Management, Inc.	50.00%	65		65	5
6	V	22 Payroll Taxes		Nivram Management, Inc.	50.00%	27,366		27,366	6
7	V	5 Utilities		Nivram Management, Inc.	50.00%	2,734		2,734	7
8	V	26 Insurance		Nivram Management, Inc.	50.00%	1,563		1,563	8
9	V	6 Repairs & Maintenance		Nivram Management, Inc.	50.00%	1,935		1,935	9
10	V	22 Health Insurance		Nivram Management, Inc.	50.00%	10,403		10,403	10
11	V	7 Scavenger		Nivram Management, Inc.	50.00%	170		170	11
12	V	35 Rental Equipment		Nivram Management, Inc.	50.00%	550		550	12
13	V	2 Sales Taxes		Nivram Management, Inc.	50.00%	388		388	13
14	Total		\$			\$ 46,972	\$ *	46,972	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	21 Postage	\$	Nivram Management, Inc.	50.00%	\$ 380	\$	380	15
16	V	19 Legal & Accounting		Nivram Management, Inc.	50.00%	703		703	16
17	V	20 Licenses & Permits		Nivram Management, Inc.	50.00%	155		155	17
18	V	25 Travel		Nivram Management, Inc.	50.00%	28		28	18
19	V	30 Depreciation		Nivram Management, Inc.	50.00%	1,294		1,294	19
20	V	21 Data Processing		Nivram Management, Inc.	50.00%	491		491	20
21	V	21 Telephone		Nivram Management, Inc.	50.00%	2,068		2,068	21
22	V	6 Plant Salary		Nivram Management, Inc.	50.00%	37,243		37,243	22
23	V	17 Assistant Administrator Salary		Nivram Management, Inc.	50.00%	55,865		55,865	23
24	V	21 Office Manager Salary		Nivram Management, Inc.	50.00%	40,151		40,151	24
25	V	1 Food Service Supervisor Salary		Nivram Management, Inc.	50.00%	36,000		36,000	25
26	V	17 Administrative Salaries		Nivram Management, Inc.	50.00%	116,702		116,702	26
27	V	17 Administrator Salaries		Nivram Management, Inc.	50.00%	377,229		377,229	27
28	V	21 Clerical Salaries		Nivram Management, Inc.	50.00%	74,910		74,910	28
29	V	6 Maintenance Salary		Nivram Management, Inc.	50.00%	92,385		92,385	29
30	V	17 Management Fees	896,409	Nivram Management, Inc.	50.00%			(896,409)	30
31	V	34 Rental Income	1,860,000	BM of Chicago Ridge Real Estate, LLC				(1,860,000)	31
32	V	32 Interest Income	41,940	BM of Chicago Ridge Real Estate, LLC				(41,940)	32
33	V	19 Accounting		BM of Chicago Ridge Real Estate, LLC		10,030		10,030	33
34	V	33 Real Estate Taxes		BM of Chicago Ridge Real Estate, LLC		666,091		666,091	34
35	V	26 Insurance		BM of Chicago Ridge Real Estate, LLC		237,544		237,544	35
36	V	21 Other Taxes		BM of Chicago Ridge Real Estate, LLC		250		250	36
37	V	32 Interest Expense		BM of Chicago Ridge Real Estate, LLC		802,418		802,418	37
38	V	30 Depreciation		BM of Chicago Ridge Real Estate, LLC		431,909		431,909	38
39	Total		\$ 2,798,349			\$ 2,983,846	\$ *	185,497	39

\* 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	31 Amortization Expense	\$	BM of Chicago Ridge Real Estate, LLC		\$ 5,873	\$	5,873	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 5,873	\$ *	5,873	39

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

Facility Name &amp; ID Number

Chicago Ridge Nursing Center

# 0045815

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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	495,074	7	17.50	Salary	\$ 100,181	17-1	1
2	Louise Mermelstein	Dietary Supervisor	Support	0.00	64,000	7	17.50	Salary	36,000	1-7	2
3	Marvin Mermelstein	Plant Supervisor	Support	40.10	58,757	5	27.78	Salary	37,243	6-7	3
4	Doreen Mermelstein	Office Manager	Administrative	0.00	74,409	8	20.00	Salary	40,151	21-7	4
5											5
6	Marvin Mermelstein	Asst. Administrator	Administrative	See Above	103,135	7	25.93	Salary	55,865	17-7	6
7	Joseph Mermelstein	Owner	Administrative	15.10	39,789	3	25.00	Salary	16,521	17-7	7
8	Barry Taerbaum	Administrator	Administrative	25.00	260,013	20	50.00	Salary	260,013	17-7	8
9	Marvin Mermelstein Family Trust		N/A	9.90	0				0		9
10	Joseph A. Mermelstein Family Trust		N/A	9.90	0				0		10
11											11
12											12
13								TOTAL	\$ 545,974		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:

01/01/2009Ending: 2/31/2009

## 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	Delivery Expense	Resident Beds	787	4	\$ 607	\$ 231	\$ 178	1	
2	21	Office Expenses	Resident Beds	787	4	4,945	231	1,451	2	
3	20	Dues & Subscriptions	Resident Beds	787	4	477	231	140	3	
4	21	Franchise Tax	Resident Beds	787	4	100	231	29	4	
5	32	Interest Expense	Resident Beds	787	4	221	231	65	5	
6	22	Payroll Taxes	Resident Beds	787	4	93,273	231	27,377	6	
7	5	Utilities	Resident Beds	787	4	9,320	231	2,736	7	
8	26	Insurance	Resident Beds	787	4	5,326	231	1,563	8	
9	6	Repairs & Maintenance	Resident Beds	787	4	6,595	231	1,936	9	
10	22	Health Insurance	Resident Beds	787	4	35,458	231	10,408	10	
11	7	Scavenger	Resident Beds	787	4	580	231	170	11	
12	35	Rental Equipment	Resident Beds	787	4	1,876	231	551	12	
13	2	Sales Taxes	Resident Beds	787	4	1,324	231	389	13	
14	21	Postage	Resident Beds	787	4	1,295	231	380	14	
15	19	Legal & Accounting	Resident Beds	787	4	2,397	231	704	15	
16	20	Licenses & Permits	Resident Beds	787	4	530	231	156	16	
17	25	Travel	Resident Beds	787	4	95	231	28	17	
18	30	Depreciation	Resident Beds	787	4	4,409	231	1,294	18	
19	21	Data Processing	Resident Beds	787	4	1,675	231	492	19	
20	21	Telephone	Resident Beds	787	4	7,048	231	2,069	20	
21	6	Plant Salary	Direct Cost	1	1	37,243	37,243	1	37,243	21
22	17	Assistant Administrator	Direct Cost	1	1	55,865	55,865	1	55,865	22
23	21	Office Manager Salary	Direct Cost	1	1	40,151	40,151	1	40,151	23
24	1	Food Service Supervisor Salary	Direct Cost	1	1	36,000	36,000	1	36,000	24
25	TOTALS					\$ 346,810	\$ 169,259	\$ 221,375	25	

Facility Name & ID Number Chicago Ridge Nursing Center

# 0045815

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	Administrative Salaries	Direct Cost	1	\$ 116,702	\$ 116,702	1	\$ 116,702	1
2	17	Administrator Salaries	Direct Cost	1	377,229	377,229	1	377,229	2
3	21	Clerical Salaries	Direct Cost	1	74,910	74,910	1	74,910	3
4	6	Maintenance Salary	Direct Cost	1	92,385	92,385	1	92,385	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				\$ 661,226	\$ 661,226		\$ 661,226	25

Facility Name & ID Number

Chicago Ridge Nursing Center

# 0045815

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Deutsche Bank Mortgage, Inc.		X	Mortgage	\$134,314.00	02/07/08	\$ 13,345,000	\$ 13,141,790	03/01/2043	6.0800	\$ 802,418	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6	BM of Chicago Ridge R/E, LLC	X		Unpaid Rent		1/1/09	1,657,653	487,653	06/28/2010	3.2500	38,002	6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>				\$134,314.00		\$ 15,002,653	\$ 13,629,443			\$ 840,420	9						
<b>B. Non-Facility Related*</b>																		
10	Offset Against Int Income										(41,940)	10						
11	Offset Against Int Income										(83,435)	11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (125,375)	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 15,002,653	\$ 13,629,443			\$ 715,045	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ 82,356      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.)





Facility Name & ID Number Chicago Ridge Nursing Center

# 0045815 Report Period Beginning:

01/01/2009 Ending:

12/31/2009

**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:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home	73,980	7/31/2007	\$ 435,000	1
2					2
3	TOTALS	73,980		\$ 435,000	3

Facility Name &amp; ID Number Chicago Ridge Nursing Center

# 0045815

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

## 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	\$	\$ 617,459	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sign		2001		1,419	37	39	37		296	9
10	Carpet		2002		2,240	57	39	57		433	10
11	Alarm		2002		22,000	564	39	564		4,066	11
12	Washer & Dryer		2002		29,304	751	39	751		5,917	12
13	Phone System		2002		10,667	274	39	274		1,926	13
14	A/C System		2002		11,200	287	39	287		2,022	14
15	Electrical Improvements		2002		3,000	77	39	77		542	15
16	Light Fixtures		2002		10,192	261	39	261		1,840	16
17	RC Alarm		2003		4,500	116	39	116		779	17
18	Water Heater		2003		16,500		5			16,500	18
19	Boiler		2004		21,500	551	39	551		2,756	19
20	Paving Improvements		2005		21,800	1,453	39	1,453		6,782	20
21	Bathroom Improvements		2005		634	16	39	16		72	21
22	Fire Smoke Dampers		2005		3,475	89	39	89		438	22
23	Boiler		2005		11,960	1,309	5	1,309		10,815	23
24	Locks		2006		4,374	112	39	112		346	24
25	Fire Alarm System		2006		98,711	2,531	39	2,531		7,804	25
26	AC Chiller Unit		2006		81,000	2,077	39	2,077		7,962	26
27	Furnace		2007		13,500	347	39	347		1,010	27
28	Temp Reset Control for Boiler		2007		2,750	71	39	71		200	28
29	Faucets		2007		2,298	59	39	59		167	29
30	Electrical Disconnect for Chiller Unit		2007		8,000	205	39	205		581	30
31	Add'l Amount for '06 AC Chiller Unit		2007		8,000	205	39	205		564	31
32	Hot Water Storage Tank		2007		22,000	564	39	564		1,457	32
33	Control System for New Chiller		2007		1,191	30	39	30		81	33
34	Grab Bars		2007		4,941	126	39	126		327	34
35	Boiler Room Change-Over Valves		2007		8,380	215	39	215		537	35
36	Water Cooler, attached to Bld		2007		1,087	28	39	28		79	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

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	\$ 81	39	\$ 81	\$	\$ 168	37
38	2009	7,784	100	39	100		100	38
39	2009	7,098	91	39	91		91	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)		\$ 10,381,586	\$ 268,184		\$ 268,184	\$ 694,117	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:

01/01/2009

Ending:

12/31/2009

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	\$ 46,906	\$ 8,175	\$ 9,381	\$ 1,206	5	\$ 30,272	71
72	Current Year Purchases	11,610	774	774		5	774	72
73	Fully Depreciated Assets	46,336				5-7	46,336	73
74	Management & Real Estate Co	1,764,084	177,703	178,542	839	10	428,454	74
75	TOTALS	\$ 1,868,936	\$ 186,652	\$ 188,697	\$ 2,045		\$ 505,836	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)	\$ 12,685,522	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 454,836	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 456,881	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,045	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,199,953	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:				\$ _____			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ _____			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 \_\_\_\_\_

0

N/A

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: \$ 990 Description: Copier - \$440; Management Company Copier - \$550

(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. \_\_\_\_\_ \$ \_\_\_\_\_

13. \_\_\_\_\_ \$ \_\_\_\_\_

14. \_\_\_\_\_ \$ \_\_\_\_\_

\* 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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
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)	
<b>TOTAL TRAINED</b>	

- (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			266,534			266,534	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 prescripts				208,410		208,410	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>Attached Schedule</u>						26,723		26,723	13
14	TOTAL			\$		\$ 266,534	\$ 235,133		\$ 501,667	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.

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/2009**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 410,566	\$ 1,222,125	1
2	Cash-Patient Deposits	72,290	72,290	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	933,803	933,803	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,534	19,534	6
7	Other Prepaid Expenses	19,132	96,650	7
8	Accounts Receivable (owners or related parties)	653	526,309	8
9	Other(specify): <u>Attached Schedule</u>	13,455	476,476	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,469,433	\$ 3,347,187	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		435,000	13
14	Buildings, at Historical Cost		9,936,943	14
15	Leasehold Improvements, at Historical Cost	386,882	386,882	15
16	Equipment, at Historical Cost	162,615	1,926,699	16
17	Accumulated Depreciation (book methods)	(152,834)	(1,196,614)	17
18	Deferred Charges		194,299	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): <u>Deposits</u>	2,635	241,949	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 399,298	\$ 11,925,158	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,868,731	\$ 15,272,345	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 743,109	\$ 784,455	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	49,165	49,165	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	144,665	144,665	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		596,304	32
33	Accrued Interest Payable	38,003	104,640	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Schedule Attached</u>	2,898,654	2,914,698	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 3,873,596	\$ 4,593,927	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		13,141,790	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 13,141,790	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,873,596	\$ 17,735,717	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (2,004,865)	\$ (2,463,372)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,868,731	\$ 15,272,345	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(617,184)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(617,184)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>2,812,319</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(4,200,000)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(1,387,681)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(2,004,865)</b>	<b>24</b> *

\* 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 10,339,757	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 10,339,757	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	66,962	6
7	Oxygen	49,281	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 116,243	8
<b>C. Other Operating Revenue</b>			
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		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	83,435	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 83,435	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Vending Income	4,290	28
28a	Attached Schedule	22,910	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 27,200	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 10,566,635	30

2

Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,280,626	31
32	Health Care	2,438,941	32
33	General Administration	1,486,520	33
<b>B. Capital Expense</b>			
34	Ownership	1,920,089	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	501,667	35
36	Provider Participation Fee	126,473	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,754,316	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	2,812,319	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 2,812,319	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:

01/01/2009

Ending:

12/31/2009

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	2,401	2,569	\$ 82,583	\$ 32.15	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,648	10,256	268,449	26.17	3
4	Licensed Practical Nurses	38,423	38,631	803,137	20.79	4
5	CNAs & Orderlies	68,630	71,638	679,468	9.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,160	2,200	28,845	13.11	9
10	Activity Assistants	6,631	7,132	53,487	7.50	10
11	Social Service Workers	8,654	8,963	130,028	14.51	11
12	Dietician					12
13	Food Service Supervisor	4,240	4,308	51,466	11.95	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,656	24,320	222,865	9.16	15
16	Dishwashers					16
17	Maintenance Workers	2,388	2,564	28,198	11.00	17
18	Housekeepers	26,518	27,952	237,443	8.49	18
19	Laundry	9,635	10,445	86,870	8.32	19
20	Administrator					20
21	Assistant Administrator	2,080	2,080	50,144	24.11	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,877	7,024	56,204	8.00	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	1,618	1,624	14,857	9.15	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	212,559	221,706	\$ 2,794,044 *	\$ 12.60	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 8,758	1-3	35
36	Medical Director	O			36
37	Medical Records Consultant	N	2,345	10-3	37
38	Nurse Consultant	T			38
39	Pharmacist Consultant	H	3,057	10-3	39
40	Physical Therapy Consultant	L			40
41	Occupational Therapy Consultant	Y			41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	F			43
44	Activity Consultant	E			44
45	Social Service Consultant	E	4,832	12-3	45
46	Other(specify)	S			46
47	MDS/Care Plan Consultant		31,097	10-3	47
48	Quality Therapy Consultant		390	10-3	48
49	TOTAL (lines 35 - 48)		\$ 50,479		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	8,573	\$ 209,619	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	8,573	\$ 209,619		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			
Darlene Guzy	Assistant Admin	0	\$ 50,144	Workers' Compensation Insurance	\$ 39,239	IDPH License Fee	\$			
				Unemployment Compensation Insurance	30,019	Advertising: Employee Recruitment	1,820			
				FICA Taxes	211,099	Health Care Worker Background Check				
				Employee Health Insurance	24,503	(Indicate # of checks performed 126 )	894			
				Employee Meals		Patient Background Checks	124 1,240			
				Illinois Municipal Retirement Fund (IMRF)*		Yellow Pages Advertising	6,000			
				Allocation from Management Company	37,769	Attached Schedule	14,159			
				Employee Benefits	1,250	Allocation from Management Company	295			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 50,144	TOTAL (agree to Schedule V, line 22, col.8)			\$ 343,879	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 18,408
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			\$ 896,409			\$	Out-of-State Travel	\$		
							In-State Travel			
							Seminar Expense	600		
							Entertainment Expense	( )		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 896,409	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 600
C. Professional Services										
Vendor/Payee	Type		Amount							
See Attached Schedule			\$ 61,614							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 61,614							

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number Chicago Ridge Nursing Center# 0045815Report Period Beginning: 01/01/2009Ending: 12/31/2009**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 \$17,775
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? \_\_\_\_\_
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line N/A
- (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. \$ 126,473  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (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.** \$ No
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (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