

Facility Name & ID Number CLARIDGE HEALTHCARE CENTER

0047241 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 _____

	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	160	Skilled (SNF)	160	58,400	1
2		Skilled Pediatric (SNF/PED)			2
3	71	Intermediate (ICF)	71	25,915	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	231	TOTALS	231	84,315	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	15,678	1,390	2,047	19,115	8
9	SNF/PED					9
10	ICF	13,995	1,270	109	15,374	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,673	2,660	2,156	34,489	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 40.90%

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

0 (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)

NONE

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 07/01/05

J. Was the facility purchased or leased after January 1, 1978?

YES Date 07/01/05 NO

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

YES NO If YES, enter number of beds certified 42 and days of care provided 1,673

Medicare Intermediary NATIONAL GOVERNMENT SERVICES INC

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

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	168,756	14,000	9,259	192,015		192,015	192,015		1	
2	Food Purchase		133,276		133,276		133,276	133,276		2	
3	Housekeeping	121,766	16,367		138,133		138,133	138,133		3	
4	Laundry	30,219	7,756	3,107	41,082		41,082	41,082		4	
5	Heat and Other Utilities			133,708	133,708		133,708	133,708		5	
6	Maintenance	39,479	33,281	44,359	117,119		117,119	1,391 118,510		6	
7	Other (specify):*			12,441	12,441		12,441	12,441		7	
8	TOTAL General Services	360,220	204,680	202,874	767,774		767,774	1,391 769,165		8	
	B. Health Care and Programs										
9	Medical Director			36,000	36,000		36,000	36,000		9	
10	Nursing and Medical Records	1,091,001	81,736	762,298	1,935,035		1,935,035	1,935,035		10	
10a	Therapy	17,190		563	17,753		17,753	17,753		10a	
11	Activities	86,565	3,016	2,472	92,053		92,053	92,053		11	
12	Social Services	46,384			46,384		46,384	46,384		12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	1,241,140	84,752	801,333	2,127,225		2,127,225	2,127,225		16	
	C. General Administration										
17	Administrative	17,210			17,210		17,210	17,210		17	
18	Directors Fees									18	
19	Professional Services			189,709	189,709		189,709	(35,400) 154,309		19	
20	Dues, Fees, Subscriptions & Promotions			26,214	26,214		26,214	(24,501) 1,713		20	
21	Clerical & General Office Expenses	87,728	18,608	57,850	164,186		164,186	(6,387) 157,799		21	
22	Employee Benefits & Payroll Taxes			236,184	236,184		236,184	236,184		22	
23	Inservice Training & Education			4,894	4,894		4,894	4,894		23	
24	Travel and Seminar									24	
25	Other Admin. Staff Transportation			3,137	3,137		3,137	3,137		25	
26	Insurance-Prop.Liab.Malpractice			153,353	153,353		153,353	43,739 197,092		26	
27	Other (specify):*			60,000	60,000		60,000	(60,000)		27	
28	TOTAL General Administration	104,938	18,608	731,341	854,887		854,887	(82,549) 772,338		28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,706,298	308,040	1,735,548	3,749,886		3,749,886	(81,158) 3,668,728		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.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	9,259
	REPAIRS & MAINTENANCE	0
		0
		9,259
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	3,107
		0
		3,107
5	HEAT & OTHER UTILITIES	
	GAS HEAT	38,978
	ELECTRICITY	63,736
	WATER	30,994
	CABLE TV - LOBBY	0
		0
		133,708
6	MAINTENANCE	
	GROUNDS MAINTENANCE	17,684
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	3,138
	ELEVATOR MAINTENANCE & REPAIR	3,868
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,300
	FIRE SERVICE	15,369
		0
		0
		0
		0
		44,359
7	OTHER	
	SCAVENGER	12,441
	SECURITY SERVICE	0
		0
		0
		12,441
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	36,000
		36,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	756,758
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	539
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	400
	PHARMACY CONSULTANT XVIII B 39-2	1,800
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	2,801
		0
		0
		762,298
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	463
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	100
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		563
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,472
		0
		2,472
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
		0
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
18	DIRECTORS FEES	
	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	10,051
	ADMINISTRATIVE CONSULTANTS XIX C	61,177
	PROFESSIONAL FEES XIX C	118,481
		0
		189,709
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	24,501
	EMPLOYEE WANT ADS XIX F	0
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	527
	LICENSES & PERMITS XIX F	496
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	270
	PATIENT BACKGROUND CHECKS XIX F	420
		26,214
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	217
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	39,806
	PENALTIES / OVERDRAFT CHARGES VI 18	6,387
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	11,440
	MESSENGER SERVICE	0
		0
		57,850

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	130,532
	UNEMPLOYMENT COMPENSATION XIX D	30,278
	WORKERS COMPENSATION INSURANC XIX D	61,301
	HOSPITALIZATION INSURANCE XIX D	13,373
	EMPLOYEE BENEFITS - OTHER XIX D	0
	EMPLOYEE PHYSICAL EXAMS XIX D	700
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		236,184
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	4,894
		4,894
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	3,137
		3,137
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	153,353
		153,353
27	OTHER	
	BAD DEBTS VI 24	60,000
		60,000

GRAND TOTAL COLUMN 3 OTHER

1,735,548

CLARIDGE HEALTHCARE CENTER
SCHEDULES
12/31/2009

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	133,276	
LESS SALES TAX	<u>0</u>	HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??
NET FOOD	133,276	
TOTAL PATIENT CENSUS	34,489	
TIME 3 MEALS PER DAY	<u>3</u>	
TOTAL PATIENT MEALS	103,467	
ADD # EMPLOYEE MEALS/DAY	0	
TIME # DAYS	<u>365</u>	
TOTAL EMPLOYEE MEALS	0	
PATIENT MEALS	103,467	
ADD EMPLOYEE MEALS	<u>0</u>	
TOTAL MEALS/YEAR	103,467	
NET FOOD	133,276	
DIVIDE TOTAL MEALS/YEAR	<u>103,467</u>	
COST PER MEAL	1.29	
TIME EMPLOYEE MEALS	<u>0</u>	
EMPLOYEE MEAL RECLASSIFICATION	0	
	=====	

Facility Name & ID Number CLARIDGE HEALTHCARE CENTER

#0047241

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

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	
	D. Ownership											
30	Depreciation			40,991	40,991		40,991	(5,661)	35,330			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			147,443	147,443		147,443	535,268	682,711			32
33	Real Estate Taxes							149,663	149,663			33
34	Rent-Facility & Grounds			960,000	960,000		960,000	(960,000)				34
35	Rent-Equipment & Vehicles			7,150	7,150		7,150		7,150			35
36	Other (specify):*											36
37	TOTAL Ownership			1,155,584	1,155,584		1,155,584	(280,730)	874,854			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		52,944	205,033	257,977		257,977		257,977			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			126,473	126,473		126,473		126,473			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		52,944	331,506	384,450		384,450		384,450			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,706,298	360,984	3,222,638	5,289,920		5,289,920	(361,888)	4,928,032			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	(5,661)	30		9
10	Interest and Other Investment Income	(24)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(32,343)	32		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	(6,387)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(35,400)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,000)	27		24
25	Fund Raising, Advertising and Promotional	(24,501)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	1,391			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (162,925)		\$	30

BHF USE ONLY					
48		49		50	51
					52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(198,963)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (198,963)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (361,888)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

CLARIDGE HEALTHCARE CENTER

ID# 0047241

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	DEFERRED MAINTENANCE	\$ 1391	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		1,391	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CLARIDGE HEALTHCARE CENTER# 0047241

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	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	1,391	0	0	0	0	0	0	0	0	0	0	1,391	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	1,391	0	0	0	0	0	0	0	0	0	0	1,391	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(35,400)	0	0	0	0	0	0	0	0	0	0	(35,400)	19
20	Fees, Subscriptions & Promotions	(24,501)	0	0	0	0	0	0	0	0	0	0	(24,501)	20
21	Clerical & General Office Expenses	(6,387)	0	0	0	0	0	0	0	0	0	0	(6,387)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	43,739	0	0	0	0	0	0	0	0	0	43,739	26
27	Other (specify):*	(60,000)	0	0	0	0	0	0	0	0	0	0	(60,000)	27
28	TOTAL General Administration	(126,288)	43,739	0	(82,549)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(124,897)	43,739	0	(81,158)	29								

STATE OF ILLINOIS

Facility Name & ID Number CLARIDGE HEALTHCARE CENTER# 0047241

Report Period Beginning:

01/01/2009 Ending:

Summary B

12/31/2009

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	(5,661)	0	0	0	0	0	0	0	0	0	0	(5,661)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(32,367)	567,635	0	0	0	0	0	0	0	0	0	535,268	32
33	Real Estate Taxes	0	149,663	0	0	0	0	0	0	0	0	0	149,663	33
34	Rent-Facility & Grounds	0	(960,000)	0	0	0	0	0	0	0	0	0	(960,000)	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	(38,028)	(242,702)	0	(280,730)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(162,925)	(198,963)	0	0	0	0	0	0	0	0	0	(361,888)	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
MRS CHOON CHI	96	N/A		PNI	CHICAGO	NURSE REGISTRY
RICHARD SCOTT O'BRIEN	4			CLARIDGE REAL ESTATE LLC	LAKE BLUFF	REAL ESTATE

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 RENT	\$ 960,000	CLARIDGE REAL ESTATE LLC	100.00%	\$	\$ (960,000)	1
2	V							2
3	V	26 INSURANCE		CLARIDGE REAL ESTATE LLC		9,223	9,223	3
4	V	33 REAL ESTATE TAXES		CLARIDGE REAL ESTATE LLC		149,663	149,663	4
5	V	32 INTEREST		CLARIDGE REAL ESTATE LLC		567,635	567,635	5
6	V	26 MIP INSURANCE		CLARIDGE REAL ESTATE LLC		34,516	34,516	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 960,000			\$ 761,037	\$ * (198,963)	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	10 CONTRACT NURSING	\$ 756,638	PNI	100.00%	\$ 756,638	\$	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		\$ 756,638			\$ 756,638	\$ *	39

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

Facility Name & ID Number CLARIDGE HEALTHCARE CENTER # 0047241 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	MRS CHOON CHI	ADMINISTRATIVE		96.00					\$	1
2	RICHARD SCOTT O'BRIEN	CFO		4.00						2
3	ALEXANDER CHI	ASST ADMIN/ADMISSIONS				40	100.00	SALARY	41,800	17-1& 21-1
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$ 41,800	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 CLARIDGE HEALTHCARE CENTER

0047241 Report Period Beginning: 01/01/2009

Ending: 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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	HEARTLAND BANK		X	MORTGAGE	\$58,935.57	05/94	\$ 8,192,800	\$ 6,909,731	06/29	8.1250	\$ 567,635	1					
2												2					
3												3					
4												4					
5												5					
Working Capital																	
6	CHOON CHI	X		WORKING CAPITAL				4,320,972			107,180	6					
7	RICHARD SCOTT O'BRIEN	X		WORKING CAPITAL				300,000			40,000	7					
8												8					
9	TOTAL Facility Related				\$58,935.57		\$ 8,192,800	\$ 11,530,703			\$ 714,815	9					
B. Non-Facility Related*																	
10	IRS, IDR, ETC		X	LATE FEES							263	10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ 263	14					
15	TOTALS (line 9+line14)						\$ 8,192,800	\$ 11,530,703			\$ 715,078	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 34,516 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.)

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>149,663.13</u>	\$ <u>149,663.13</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 and 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 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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: 58,545 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 3

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).

N/A

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				\$	1
2					2
3	TOTALS			\$	3

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	2005		\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	PAINING; TILE & WALLPAPER COVERING; CEILING TILE	2005		52,239	1,900	27.5	1,900		8,154	9
10	FLOORING, COVE BASE, CARPETING	2005		57,519	2,091	27.5	2,091		8,975	10
11	STEEL DOORS	2005		16,319	593	27.5	593		2,545	11
12	PLUMBING REPAIRS; PUMPS, VALVES, MOTORS	2005		19,662	715	27.5	715		3,069	12
13	SPRINKLER SYS;SMOKE DET; FIRE DAMPER;TEMP CONTR	2005		25,043	910	27.5	910		3,907	13
14	LOBBY COUNTER & NURSES STATION	2005		10,758	391	27.5	391		1,678	14
15	WINDOW TREATMENT; CUBICLE CURTAINS	2005		19,636	714	27.5	714		3,064	15
16	NEW SERVICES SIDEWALK	2005		2,400	87	27.5	87		374	16
17	INSULATION	2005		7,194	262	27.5	262		1,123	17
18	HANDRAILS	2006		15,358	558	27.5	558		1,930	18
19	CEILING TILES	2006		4,309	157	27.5	157		543	19
20	FIRE INSULATIONS	2006		4,400	160	27.5	160		553	20
21	FIRE ALARM SYSTEM	2007		31,590	1,149	27.5	1,149		2,825	21
22	HEATING AND AIR CONDITIONER REPAIRS	2007		26,295	956	27.5	956		2,351	22
23	WATER MAIN AND PARKING LOT REPAIR	2009		9,915	135	27.5	135		135	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

*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 **CLARIDGE HEALTHCARE CENTER**

0047241

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 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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									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)		\$ 302,637	\$ 10,778		\$ 10,778	\$	\$ 41,226	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	\$ 245,518	\$ 30,213	\$ 24,552	\$ (5,661)	10 YRS	\$ 99,488	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 245,518	\$ 30,213	\$ 24,552	\$ (5,661)		\$ 99,488	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)	\$ 548,155	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 40,991	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 35,330	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (5,661)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 140,714	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

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. 12/31/2010 \$ _____

13. 12/31/2011 \$ _____

14. 12/31/2012 \$ _____

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: \$ 7,150 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED		
1. From this facility		
2. From other facilities (f)		
DROP-OUTS		
1. From this facility		
2. From other facilities (f)		
TOTAL TRAINED		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2 Staff		3 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 112,555	\$		\$ 112,555	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			2,184			2,184	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			90,294			90,294	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				50,920		50,920	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): MED SUP, LAB, ETC	39-2					2,024		2,024	13
14	TOTAL			\$		\$ 205,033	\$ 52,944		\$ 257,977	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 **CLARIDGE HEALTHCARE CENTER**

0047241

Report Period Beginning: **01/01/2009**

Ending:

12/31/2009

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 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 388,171)	901,500		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	104,882		6
7	Other Prepaid Expenses	84,931		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): DUE FROM PRIOR OWNER	5,351		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,096,664	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	302,637		15
16	Equipment, at Historical Cost	245,518		16
17	Accumulated Depreciation (book methods)	(253,420)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): SECURITY DEPOSITS	17,254		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 311,989	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,408,653	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 2,621,813	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	52,765		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,256		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,682,834	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	DUE TO RELATED PARTIES	4,646,498		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,646,498	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,329,332	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (5,920,679)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,408,653	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (5,002,104)	1
2	Restatements (describe):		2
3	ROUNDING		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (5,002,104)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(918,575)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (918,575)	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)	\$ (5,920,679)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,522,434	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,522,434	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	194,247	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 194,247	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	150	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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 150	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	24	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 24	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING INCOME NET	300	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 300	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,717,155	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	767,774	31
32	Health Care	2,127,225	32
33	General Administration	854,887	33
B. Capital Expense			
34	Ownership	1,155,584	34
C. Ancillary Expense			
35	Special Cost Centers	257,977	35
36	Provider Participation Fee	126,473	36
D. Other Expenses (specify):			
37	OUT-OF-PERIOD EXPENSES	345,810	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,635,730	40
41	Income before Income Taxes (line 30 minus line 40)**	(918,575)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (918,575)	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.
TAX RETURN PREPARED ON CASH BASIS

*** 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 **CLARIDGE HEALTHCARE CENTER**

0047241

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	2,727	2,907	\$ 109,350	\$ 37.62	1
2	Assistant Director of Nursing					2
3	Registered Nurses	19,138	19,720	554,078	28.10	3
4	Licensed Practical Nurses	6,217	6,377	156,099	24.48	4
5	CNAs & Orderlies	14,697	16,391	187,990	11.47	5
6	CNA Trainees					6
7	Licensed Therapist	240	240	17,190	71.63	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,826	2,929	33,537	11.45	9
10	Activity Assistants	4,551	4,727	53,028	11.22	10
11	Social Service Workers	3,265	3,455	46,384	13.43	11
12	Dietician					12
13	Food Service Supervisor	2,865	2,992	37,364	12.49	13
14	Head Cook	2,587	2,676	28,154	10.52	14
15	Cook Helpers/Assistants	11,224	11,555	103,238	8.93	15
16	Dishwashers					16
17	Maintenance Workers	2,082	2,152	39,479	18.35	17
18	Housekeepers	14,272	14,846	121,766	8.20	18
19	Laundry	3,523	3,722	30,219	8.12	19
20	Administrator	432	432	8,307	19.23	20
21	Assistant Administrator	400	400	8,903	22.26	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,629	7,795	87,728	11.25	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	1,829	1,924	20,172	10.48	31
32	Other Health C: REHAB DIR/MDS	2,088	2,262	63,312	27.99	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	102,592	107,502	\$ 1,706,298 *	\$ 15.87	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	\$ 9,259	1-3	35
36	Medical Director	O	36,000	9-3	36
37	Medical Records Consultant	N	400	10-3	37
38	Nurse Consultant	T	2,801	10-3	38
39	Pharmacist Consultant	H	1,800	10-3	39
40	Physical Therapy Consultant	L	463	10a-3	40
41	Occupational Therapy Consultant	Y	100	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,472	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 53,295		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	5,179	\$ 133,793	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides	44,288	622,965	10-3	52
53	TOTAL (lines 50 - 52)	49,467	\$ 756,758		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	
RICHARD HORWITZ	ADMINISTRATOR		\$ 8,307	Workers' Compensation Insurance	\$ 61,301	IDPH License Fee	\$ 164	
ALEXANDER CHI	ASST ADMIN		8,903	Unemployment Compensation Insurance	30,278	Advertising: Employee Recruitment	0	
				FICA Taxes	130,532	Health Care Worker Background Check	270	
				Employee Health Insurance	13,373	(Indicate # of checks performed <u>27</u>)		
				Employee Meals	0	Patient Background Checks	42	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	0	
				EMPLOYEE BENEFITS - OTHER	0	MARKETING/ADV/PROMO	24,501	
				EMPLOYEE PHYSICAL EXAMS	700	LICENSES/DUES/SUBSCRIPTIONS	859	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC		
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	0	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(24,501)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 17,210	TOTAL (agree to Schedule V, line 22, col.8)	\$ 236,184	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 1,713	
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
			\$			\$	Out-of-State Travel	\$
							In-State Travel	0
							Seminar Expense	0
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$
SEE SCHEDULE ATTACHED			189,709					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 189,709					

* Attach copy of IMRF notifications

**See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	PAINT/DECORATING	\$ 8,344		\$ 1,391	\$ 2,781	\$ 2,781	\$ 1,391	\$	\$	\$	\$	\$
2												
3												
4												
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16												
17												
18												
19												
20	TOTALS	\$ 8,344		\$ 1,391	\$ 2,781	\$ 2,781	\$ 1,391	\$	\$	\$	\$	\$

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? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (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? _____
- (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? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,541 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 126,473
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 - c. What percent of all travel expense relates to transportation of nurses and patients? 5%
 - d. Have vehicle usage logs been maintained? NO
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
 - g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (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.