

Facility Name & ID Number Norrridge Healthcare & Rehab Centre

0032011 Report Period Beginning: 1-Jan-2009 Ending: 31-Dec-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 23-Jan-2009

	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>303</u>	Skilled (SNF)	<u>292</u>	<u>106,822</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>303</u>	TOTALS	<u>292</u>	<u>106,822</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF	<u>36,811</u>	<u>8,001</u>	<u>20,581</u>	<u>65,393</u>	8
9	SNF/PED					9
10	ICF	<u>24,386</u>	<u>4,564</u>	<u>174</u>	<u>29,124</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>61,197</u>	<u>12,565</u>	<u>20,755</u>	<u>94,517</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.48%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
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 1-Jan-1987

J. Was the facility purchased or leased after January 1, 1978?
YES Date 1-Jan-1987 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 292 and days of care provided 19,230

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 31-Dec-2009 Fiscal Year: 31-Dec-2009

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

Facility Name & ID Number Norrridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-2009 Ending: 31-Dec-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
	A. General Services										
1	Dietary	726,241	64,553	22,421	813,215		813,215		813,215		1
2	Food Purchase		700,759		700,759	(29,893)	670,866	(438)	670,428		2
3	Housekeeping	511,492	138,882		650,374		650,374		650,374		3
4	Laundry	210,997	52,300		263,297		263,297		263,297		4
5	Heat and Other Utilities			357,013	357,013		357,013		357,013		5
6	Maintenance	58,097	101,981	169,234	329,312		329,312	3,317	332,629		6
7	Other (specify):*										7
8	TOTAL General Services	1,506,827	1,058,475	548,668	3,113,970	(29,893)	3,084,077	2,879	3,086,956		8
	B. Health Care and Programs										
9	Medical Director			33,000	33,000		33,000		33,000		9
10	Nursing and Medical Records	6,215,677	649,355	34,569	6,899,601		6,899,601		6,899,601		10
10a	Therapy		16,899	48,536	65,435		65,435		65,435		10a
11	Activities	216,600	44,237		260,837		260,837		260,837		11
12	Social Services	148,764		3,920	152,684		152,684		152,684		12
13	CNA Training		1,020	2,200	3,220		3,220		3,220		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	6,581,041	711,511	122,225	7,414,777		7,414,777		7,414,777		16
	C. General Administration										
17	Administrative	154,575		509,040	663,615		663,615	(290,505)	373,110		17
18	Directors Fees										18
19	Professional Services			72,267	72,267		72,267	9,826	82,093		19
20	Dues, Fees, Subscriptions & Promotions			48,785	48,785		48,785	(24,771)	24,014		20
21	Clerical & General Office Expenses	383,554	102,049	146,342	631,945		631,945	72,881	704,826		21
22	Employee Benefits & Payroll Taxes			1,374,111	1,374,111	29,893	1,404,004	17,347	1,421,351		22
23	Inservice Training & Education			2,630	2,630		2,630	5,687	8,317		23
24	Travel and Seminar			12,402	12,402		12,402	2,455	14,857		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			65,118	65,118		65,118		65,118		26
27	Other (specify):*							37,268	37,268		27
28	TOTAL General Administration	538,129	102,049	2,230,695	2,870,873	29,893	2,900,766	(169,812)	2,730,954		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,625,997	1,872,035	2,901,588	13,399,620		13,399,620	(166,933)	13,232,687		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 (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			173,268	173,268		173,268	2,260,576	2,433,844			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							1,453,481	1,453,481			32
33	Real Estate Taxes			599,066	599,066		599,066		599,066			33
34	Rent-Facility & Grounds			2,489,239	2,489,239		2,489,239	(2,484,000)	5,239			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			3,261,573	3,261,573		3,261,573	1,230,057	4,491,630			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		902,891	1,514,421	2,417,312		2,417,312		2,417,312			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			160,232	160,232		160,232		160,232			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		902,891	1,674,653	2,577,544		2,577,544		2,577,544			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	8,625,997	2,774,926	7,837,814	19,238,737		19,238,737	1,063,124	20,301,861			45

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

Norridge Healthcare & Rehab Centre

ID# 0032011

Report Period Beginning: 1-Jan-2009

Ending: 31-Dec-2009

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Painting & Decorating incurred in 2009	\$	(1,535)	6 1
2	Painting & Decorating allocated for 2009		459	6 2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(1,076)	49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

1-Jan-2009

Ending:

31-Dec-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	(438)	0	0	0	0	0	0	0	0	0	0	(438)	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	(1,076)	4,393	0	0	0	0	0	0	0	0	0	3,317	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,514)	4,393	0	0	0	0	0	0	0	0	0	2,879	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	(290,505)	0	0	0	0	0	0	0	0	0	(290,505)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	7,276	2,550	0	0	0	0	0	0	0	0	9,826	19
20	Fees, Subscriptions & Promotions	(128,780)	104,009	0	0	0	0	0	0	0	0	0	(24,771)	20
21	Clerical & General Office Expenses	(101,721)	169,443	5,159	0	0	0	0	0	0	0	0	72,881	21
22	Employee Benefits & Payroll Taxes	0	17,347	0	0	0	0	0	0	0	0	0	17,347	22
23	Inservice Training & Education	0	5,687	0	0	0	0	0	0	0	0	0	5,687	23
24	Travel and Seminar	0	2,455	0	0	0	0	0	0	0	0	0	2,455	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	37,268	0	0	0	0	0	0	0	0	0	37,268	27
28	TOTAL General Administration	(230,501)	52,980	7,709	0	(169,812)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(232,015)	57,373	7,709	0	(166,933)	29							

STATE OF ILLINOIS

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

Report Period Beginning:

1-Jan-2009 Ending:

Summary B

31-Dec-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	2,071,086	5,854	183,636	0	0	0	0	0	0	0	0	2,260,576	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(71,429)	45,229	1,479,681	0	0	0	0	0	0	0	0	1,453,481	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(2,484,000)	0	0	0	0	0	0	0	0	(2,484,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	1,999,657	51,083	(820,683)	0	1,230,057	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)	1,767,642	108,456	(812,974)	0	0	0	0	0	0	0	0	1,063,124	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 Management Fee Income	\$ 509,040	Lancaster, Ltd.	100.00%	\$	(509,040)	1
2	V	17 Officers' Salaries		Lancaster, Ltd.	100.00%	64,570	64,570	2
3	V	27 Payroll Taxes-Officers & Staff		Lancaster, Ltd.	100.00%	37,268	37,268	3
4	V	19 Professional Services		Lancaster, Ltd.	100.00%	7,276	7,276	4
5	V	21 Clerical Expenses		Lancaster, Ltd.	100.00%	169,443	169,443	5
6	V	22 E,mployee Benefits		Lancaster, Ltd.	100.00%	17,347	17,347	6
7	V	24 Seminars and Travel		Lancaster, Ltd.	100.00%	2,455	2,455	7
8	V	6 Repairs and Maintenance		Lancaster, Ltd.	100.00%	4,393	4,393	8
9	V	17 Administrative Consulting		Lancaster, Ltd.	100.00%	153,965	153,965	9
10	V	32 Interest including Direct Interest		Lancaster, Ltd.	100.00%	45,229	45,229	10
11	V	30 Depreciation		Lancaster, Ltd.	100.00%	5,854	5,854	11
12	V	20 Dues, Fees and Sub/Mrkt Fees		Lancaster, Ltd.	100.00%	104,009	104,009	12
13	V	23 Education & Inservice		Lancaster, Ltd.	100.00%	5,687	5,687	13
14	Total		\$ 509,040			\$ 617,496	\$ * 108,456	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	34 Rental Income	\$ 2,484,000	Norridge Associates		\$	\$ (2,484,000)
16	V	32 Interest	20,319	Norridge Associates		1,500,000	1,479,681
17	V	30 Depreciation		Norridge Associates		183,636	183,636
18	V	19 Accounting Fees		Norridge Associates		2,550	2,550
19	V	21 State Replacement Tax		Norridge Associates		5,159	5,159
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 2,504,319			\$ 1,691,345	\$ * (812,974)

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

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-2009 Ending: 31-Dec-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	Christopher Vicere	VP-Finance	Administrative		See Attached	9	18.75	Lancaster	\$ 32,285	17-7	1
2	Cheryl Morris	VP-Operations	Administrative		See Attached	9	18.75	Lancaster	32,285	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 64,570		13

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

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

Facility Name & ID Number Norridge Healthcare & Rehab Centre

0032011

Report Period Beginning:

1-Jan-2009

Ending: -Dec-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 Lancaster, Ltd.
 Street Address 5061 N. Pulaski Road
 City / State / Zip Code Chicago, IL 60630
 Phone Number (773)604-4416
 Fax Number (773)478-1192

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Christopher Vicere	Hours Worked	48	7	\$ 172,189	\$ 172,189	9	\$ 32,285	1
2	27	Christopher Vicere-payroll tax	Hours Worked	48	7	9,309		9	1,745	2
3	17	Cheryl Morris	Hours Worked	48	7	172,189	172,189	9	32,285	3
4	27	Cheryl Morris-payroll tax	Hours Worked	48	7	9,309		9	1,745	4
5										5
6										6
7										7
8										8
9										9
10	19	Professional Services	Management Fees	2,190,720	7	31,315		509,040	7,276	10
11	21	Clerical Expenses	Management Fees	2,190,720	7	729,221	681,138	509,040	169,443	11
12	22	Employee Benefits	Management Fees	2,190,720	7	74,654		509,040	17,347	12
13	24	Seminars and Travel	Management Fees	2,190,720	7	10,564		509,040	2,455	13
14	17	Administrative Consulting	Management Fees	2,190,720	7	662,608	662,608	509,040	153,965	14
15	20	Marketing Fees	Management Fees	2,190,720	7	430,592	417,882	509,040	100,053	15
16	30	Depreciation	Management Fees	2,190,720	7	25,194		509,040	5,854	16
17	20	Dues, Fees and Subscriptions	Management Fees	2,190,720	7	17,027		509,040	3,956	17
18	27	Payroll Taxes	Management Fees	2,190,720	7	145,366		509,040	33,778	18
19	6	Repairs and Maintenance	Management Fees	2,190,720	7	18,904		509,040	4,393	19
20	32	Interest	Management Fees	2,190,720	7	57,668		509,040	13,400	20
21	23	Education and Inservice	Management Fees	2,190,720	7	24,476		509,040	5,687	21
22	32	*Direct Interest*							31,829	22
23										23
24										24
25	TOTALS					\$ 2,590,585	\$ 2,106,006		\$ 617,496	25

Facility Name & ID Number

Norridge Healthcare & Rehab Centre

0032011

Report Period Beginning:

1-Jan-2009

Ending:

31-Dec-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	2	3	4	5	6		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
A. Directly Facility Related																		
Long-Term																		
1						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
Working Capital																		
6	Harston Investments		X	Working Capital						1,500,000	6							
7	JP Morgan Chase bank		X	Working Capital						13,400	7							
8											8							
9	TOTAL Facility Related					\$	\$			\$ 1,513,400	9							
B. Non-Facility Related*																		
10											10							
11											11							
12											12							
13											13							
14	TOTAL Non-Facility Related					\$	\$			\$	14							
15	TOTALS (line 9+line14)					\$	\$			\$ 1,513,400	15							

Se-Off Interest Income (59,919)

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.

\$ None

Line #

N/A

1,453,481

Pg 4 Line 32 Col 8

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Norridge Healthcare & Rehab Centre

0032011

Report Period Beginning:

1-Jan-2009 Ending:

31-Dec-2009

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1			1986	\$ 650,000	1
2					2
3	TOTALS			\$ 650,000	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		1986	1976	\$ 9,204,000	\$	30	\$ 2,009,540	\$ 2,009,540	\$ 9,204,000	4
5				1,315,965	41,777	30	59,405	17,628	755,227	5
6										6
7										7
8										8
Improvement Type**										
9	Various		1987	43,548	1,382	20	335	(1,047)	43,548	9
10	Various		1988	3,939	125	20	(438)	(563)	3,939	10
11	Various		1988	28,574	459	20	(2,660)	(3,119)	28,574	11
12	Various		1989	1,297	41	20	(49)	(90)	1,297	12
13	Various		1990	3,827	121	20	(71)	(192)	3,779	13
14	Various		1990	28,644	909	20	1,715	806	27,787	14
15	Various		1991	72,916	2,314	20	4,116	1,802	66,909	15
16	Various		1992	36,639	950	20	2,477	1,527	32,981	16
17	Various		1993	72,513	1,920	20	5,325	3,405	60,287	17
18	Various		1994	116,353	3,049	20	8,584	5,535	90,118	18
19	Various		1995	95,409	2,447	20	7,116	4,669	71,263	19
20	Boiler/Hot Water Heater Improvements		1996	9,417	241	20	700	459	6,592	20
21	Tuckpointing		1999	28,900	741	20	1,105	364	15,293	21
22	Architect Fee 1st Floor		2001	15,052	386	20	386		3,426	22
23	Construction 1st Floor		2001	166,662	4,273	20	4,273		37,924	23
24	Construction Library		2001	12,461	320	20	320		2,839	24
25	Design Fee-1st Floor		2001	5,130	132	20	132		1,171	25
26	Sprinklers-1st Floor		2001	4,531	116	20	116		1,030	26
27	Demolition-1st Floor		2001	5,533	142	20	142		1,260	27
28	Wooden Doors (2)		2001	1,134	29	20	29		258	28
29	Construction Work		2002	4,207	108	20	108		895	29
30	Smoking Shelter		2002	3,251	83	20	325	242	2,600	30
31	Auto Front Door		2002	2,074	53	20	207	154	1,570	31
32	Fence In Lot		2003	2,972	88	20	198	110	1,238	32
33	Building New-Town Square		2003	281,539	16,610	20	19,508	2,898	120,299	33
34	Roofing		2003	62,440	1,601	20	6,244	4,643	38,505	34
35	Wanderguard		2004	964		20	96	96	560	35
36	Refuse Inclosure		2004	2,395		20	240	240	1,280	36

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

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

See Page 12A, Line 70 for total

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

Report Period Beginning:

1-Jan-2009 Ending: 31-Dec-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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Fire alarm System	2004	\$ 104,400	\$ 6,013	20	\$ 14,914	\$ 8,901	\$ 85,756	37
38	Patio Concrete	2004	2,500	64	20	250	186	1,479	38
39	Air Ventilation System	2004	26,794	687	20	2,233	1,546	12,467	39
40	Design & Development of Town Square	2004	42,130	1,080	20	4,213	3,133	24,576	40
41	Consultancy Fire Alarm Installation	2004	22,700	1,308	20	3,243	1,935	18,647	41
42	Hand Rail System	2005	6,025	154	20	603	449	2,914	42
43	Duct Detectors	2005	2,061	53	20	412	359	1,992	43
44	20 Ton Roof Top Aircon	2005	17,635	452	20	3,527	3,075	16,165	44
45	Elevator Fire Upgrade	2005	46,440	1,191	20	9,288	8,097	42,570	45
46	Concrete Approach Pad	2005	2,160	55	20	216	161	954	46
47	27 Plastic Laminate Doors	2006	6,145	158	20	615	457	2,357	47
48	10T Rooftop A/C W/Exhaust	2006	24,668	632	20	2,467	1,835	8,840	48
49	Wanderguard	2006	1,000	26	20	100	74	317	49
50	Laminate 2x Egress Doors	2007	4,361	112	20	436	324	1,163	50
51	Electrical Fittings, Fixtures & Holders 2nd Floor	2007	6,512	167	20	651	484	1,465	51
52	Construction Cost-2nd Floor & Dementia Unit	2007	294,274	7,546	20	29,427	21,881	66,211	52
53	Architectural Cost-2nd Floor & Dementia Unit	2007	13,657	350	20	1,366	1,016	3,073	53
54	Wallcoverings,Borders,Accent Tiles,Murals-2nd FL	2007	41,777	1,071	20	4,178	3,107	9,401	54
55	Fixtures & Fittings Incl.countertops,Sinks&Blinds	2007	56,845	1,457	20	5,684	4,227	12,789	55
56	Glazed/Unglazed Vinyl/Ceramic Tiles&Floor Coverings	2007	34,919	895	20	3,492	2,597	7,857	56
57	Cabinetry For 2nd Floor & Dementia Unit	2007	96,950	22,105	20	19,390	(2,715)	43,628	57
58	Bed Annunciator Panel	2009	12,900	7,740	20	1,505	(6,235)	1,505	58
59	Islandaire Unit	2009	14,722	205	20	859	654	859	59
60	Replacement of Boilers	2009	97,850	524	20	2,446	1,922	2,446	60
61	New Gas Pipe Laid	2009	3,247	17	20	81	64	81	61
62	New Door	2009	1,552	5	20	26	21	26	62
63	30 x Signalling Boxes	2009	1,023	614	20	17	(597)	17	63
64	Renovation of 4th Floor	2009	273,095	3,214	20	13,655	10,441	13,655	64
65	4th Floor Pre-Construction	2009	7,010	83	20	351	268	351	65
66	Corner Guards,Rails,Sink,Cabinets 4th Floor	2009	21,854	13,112	20	2,185	(10,927)	2,185	66
67	Wall Protection Material & Adhesive 4th Floor	2009	21,859	13,115	20	2,186	(10,929)	2,186	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 12,941,351	\$ 164,622		\$ 2,259,540	\$ 2,094,918	\$ 11,014,381	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	\$ 788,385	\$ 101,830	\$ 140,946	\$ 39,116	7	\$ 413,082	71
72	Current Year Purchases	150,086	87,883	16,385	(71,498)	7	16,385	72
73	Fully Depreciated Assets	1,912,221	2,569	11,119	8,550	7	1,912,221	73
74	*Lancaster Allocation*		5,854	5,854			33,753	74
75	TOTALS	\$ 2,850,692	\$ 198,136	\$ 174,304	\$ (23,832)		\$ 2,375,441	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)	\$ 16,442,043	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 362,758	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 2,433,844	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,071,086	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 13,389,822	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: ***Lease held by Norridge Property Associates-a Related Party***

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					5,239			5
6								6
7	TOTAL				\$ 5,239			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2010</u>	\$ _____
13.	<u>/2011</u>	\$ _____
14.	<u>/2012</u>	\$ _____

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>96</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>48</u></p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies	87	2,113		2,200
3	Classroom Wages (a)	40	980		1,020
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 127	\$ 3,093	\$	\$ 3,220
10	SUM OF line 9, col. 1 and 2 (e)	\$ 3,220			

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	49
2. From other facilities (f)	4
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	1
TOTAL TRAINED	56

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 641,526	\$		\$ 641,526	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			171,814			171,814	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			692,130			692,130	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	39-2	hrs			8,951			8,951	8
9	Pharmacy	39-2	# of prescrpts				718,628		718,628	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>*Medical Supplies*</u>	39-2					133,375		133,375	12
13	Other (specify): <u>*Bed Rental*</u>	39-2					50,888		50,888	13
14	TOTAL			\$		\$ 1,514,421	\$ 902,891		\$ 2,417,312	14

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

Facility Name & ID Number **Norridge Healthcare & Rehab Centre**# **0032011**Report Period Beginning: **1-Jan-2009**Ending: **31-Dec-2009****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **31-Dec-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	\$ (344,289)	\$ (344,289)	1
2	Cash-Patient Deposits	67,239	67,239	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	4,531,064	4,531,064	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	65,697	65,697	6
7	Other Prepaid Expenses	17,605	17,605	7
8	Accounts Receivable (owners or related parties)	1,569,539	2,916,425	8
9	Other(specify): Employee Loans	11,329	11,329	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,918,184	\$ 7,265,070	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		776,788	13
14	Buildings, at Historical Cost		10,519,965	14
15	Leasehold Improvements, at Historical Cost	1,010,131	2,421,386	15
16	Equipment, at Historical Cost	2,245,369	2,850,694	16
17	Accumulated Depreciation (book methods)	(2,429,194)	(13,348,810)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		162,166	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(162,166)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Const-in-progress)		587,399	22
23	Other(specify): Goodwill	100,000	100,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 926,306	\$ 3,907,422	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,844,490	\$ 11,172,492	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 308,629	\$ 308,629	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	112,559	112,559	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	701,215	701,215	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,224	14,224	31
32	Accrued Real Estate Taxes(Sch.IX-B)	580,000	580,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,716,627	\$ 1,716,627	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		15,000,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 15,000,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,716,627	\$ 16,716,627	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,127,863	\$ (5,544,135)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,844,490	\$ 11,172,492	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,706,113	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,706,113	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,808,997	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) ***Treasury Stock***	(387,247)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,421,750	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)	\$ 5,127,863	24 *

* This must agree with page 17, line 47.

XVI. STATEMENT OF CHANGES IN EQUITY

		Totals after consolidation	
1	Balance at Beginning of Year, as Previously Reported	\$ (6,778,859)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (6,778,859)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,621,971	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,000,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) ***Treasury Stock***	(387,247)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,234,724	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)	\$ (5,544,135)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Norridge Healthcare & Rehab Centre**# **0032011**Report Period Beginning: **1-Jan-2009**Ending: **31-Dec-2009**

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	\$ 23,397,873	1
2	Discounts and Allowances for all Levels	(7,163,491)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 16,234,382	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,641,885	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,641,885	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	712,942	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	24,915	19
20	Radiology and X-Ray	109,829	20
21	Other Medical Services	247,352	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,095,038	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	71,429	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 71,429	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Vending Commissions</u>	5,000	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,000	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 21,047,734	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	3,113,970	31
32	Health Care	7,414,777	32
33	General Administration	2,870,873	33
B. Capital Expense			
34	Ownership	3,261,573	34
C. Ancillary Expense			
35	Special Cost Centers	2,417,312	35
36	Provider Participation Fee	160,232	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 19,238,737	40
41	Income before Income Taxes (line 30 minus line 40)**	1,808,997	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,808,997	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. *Cash Basis Taxpayer*

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

Offset pg 5 & 9

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

Facility Name & ID Number Norridge Healthcare & Rehab Centre

0032011

Report Period Beginning: 1-Jan-2009

Ending: 31-Dec-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	1,817	2,108	\$ 92,264	\$ 43.77	1
2	Assistant Director of Nursing	4,998	5,408	189,493	35.04	2
3	Registered Nurses	82,998	88,435	2,448,675	27.69	3
4	Licensed Practical Nurses	26,261	27,440	682,333	24.87	4
5	CNAs & Orderlies	224,202	242,777	2,649,059	10.91	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,979	2,330	52,078	22.35	9
10	Activity Assistants	13,589	14,730	164,522	11.17	10
11	Social Service Workers	9,529	10,561	148,764	14.09	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	55,051	60,767	726,241	11.95	15
16	Dishwashers					16
17	Maintenance Workers	3,826	4,225	58,097	13.75	17
18	Housekeepers	39,252	43,323	511,492	11.81	18
19	Laundry	19,510	21,739	210,997	9.71	19
20	Administrator	1,965	2,086	98,855	47.39	20
21	Assistant Administrator	2,093	2,142	55,720	26.01	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,977	22,863	383,554	16.78	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	8,855	9,994	153,853	15.39	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	516,902	560,928	\$ 8,625,997 *	\$ 15.38	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	645	\$ 22,421	1-3	35
36	Medical Director	887	33,000	9-3	36
37	Medical Records Consultant	174	4,696	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	1,357	45,352	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	126	3,920	12-3	45
46	Other(specify) <u>Dementia Consult</u>	110	3,184	10a-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,299	\$ 112,573		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	935	\$ 29,873	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	935	\$ 29,873		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	
Safet Keljalic	Administrator		\$ 98,855	Workers' Compensation Insurance	\$ 123,668	IDPH License Fee	\$ 2,000	
Jina Lebert-Davis	Asst. Administrator		55,720	Unemployment Compensation Insurance	65,080	Advertising: Employee Recruitment	6,698	
				FICA Taxes	649,503	Health Care Worker Background Check		
				Employee Health Insurance	407,931	(Indicate # of checks performed <u>374</u>)	3,740	
				Employee Meals	29,893	Patient Background Checks	3,620	
				Illinois Municipal Retirement Fund (IMRF)*		***Promotional Advertising***	24,771	
				Employment Fees	4,205	***Contributions***	1,250	
				Misc. Employment Benefits	36,242	***Dues & Subscriptions***	2,550	
				Uniforms	2,662	***Licenses & Fees***	4,156	
				Retiremnt Plan Contribution	84,820	***Related Parties Allocation***	104,009	
				Lancster Allocation	17,347	Less: Public Relations Expense	(22,877)	
						Non-allowable advertising	(104,009)	
						Yellow page advertising	(1,894)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
					\$ 1,421,351			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees-Lancaster, Ltd			\$ 509,040				Out-of-State Travel	\$
							In-State Travel	5,720
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 509,040				Seminar Expense	6,682
							Lancaster Allocation	2,455
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 72,267	TOTAL		\$	TOTAL	\$ 14,857

* 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	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	Painting & Decorating	July-2007	\$ 320		\$	\$ 27	\$ 53	\$ 53	\$ 27	\$	\$	\$	\$
2	Painting & Decorating	2008	900	3		27	75	150	150	75			
3	Painting & Decorating	2009	1,535	3				256	511	511	256		
4													
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20	TOTALS		\$ 2,755		\$	\$ 54	\$ 128	\$ 459	\$ 688	\$ 586	\$ 256	\$	\$

Facility Name & ID Number Norridge Healthcare & Rehab Centre# 0032011Report Period Beginning: 1-Jan-2009Ending: 31-Dec-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? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 113,005 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. 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. \$ 160,232
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? N/A 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. \$ 29,893 Has any meal income been offset against related costs? None 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? None
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?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (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.