

Facility Name & ID Number Park Ridge Care Center

0039255 Report Period Beginning: 01/01/09 Ending: 12/31/09

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 N/A

	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	46	Skilled (SNF)	46	16,790	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	46	TOTALS	46	16,790	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	352	1	1,367	1,720	8
9	SNF/PED					9
10	ICF	11,394	579	236	12,209	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,746	580	1,603	13,929	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.96%

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 12/1/1993

J. Was the facility purchased or leased after January 1, 1978?
YES Date 12/1/1993 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 46 and days of care provided 1,241

Medicare Intermediary Wisconsin Physician Services

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: 12/31/2009

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

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	183,567	6,193		189,760		189,760	(24)	189,736		1
2	Food Purchase		58,666		58,666	(504)	58,162	(24)	58,138		2
3	Housekeeping	92,101	12,196		104,297		104,297		104,297		3
4	Laundry	27,672	5,129	150	32,951		32,951	(150)	32,801		4
5	Heat and Other Utilities			40,188	40,188		40,188	(599)	39,589		5
6	Maintenance	49,211	18,142	17,462	84,815		84,815	3,092	87,907		6
7	Other (specify):*										7
8	TOTAL General Services	352,551	100,326	57,800	510,677	(504)	510,173	2,295	512,468		8
	B. Health Care and Programs										
9	Medical Director			5,800	5,800		5,800		5,800		9
10	Nursing and Medical Records	746,380	53,027	19,121	818,528		818,528	(2,531)	815,997		10
10a	Therapy										10a
11	Activities		9,247	1,281	10,528		10,528		10,528		11
12	Social Services			3,002	3,002		3,002		3,002		12
13	CNA Training										13
14	Program Transportation			1,490	1,490		1,490		1,490		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	746,380	62,274	30,694	839,348		839,348	(2,531)	836,817		16
	C. General Administration										
17	Administrative	95,740			95,740		95,740	14,025	109,765		17
18	Directors Fees										18
19	Professional Services			70,099	70,099	(14,424)	55,675	(36,603)	19,072		19
20	Dues, Fees, Subscriptions & Promotions			12,269	12,269		12,269	(6,532)	5,737		20
21	Clerical & General Office Expenses	18,667	8,375	216,028	243,070		243,070	(181,367)	61,703		21
22	Employee Benefits & Payroll Taxes			138,648	138,648	504	139,152		139,152		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,174	1,174		1,174	206	1,380		24
25	Other Admin. Staff Transportation			3,544	3,544		3,544	193	3,737		25
26	Insurance-Prop.Liab.Malpractice			16,290	16,290		16,290	55,398	71,688		26
27	Other (specify):*							5,629	5,629		27
28	TOTAL General Administration	114,407	8,375	458,052	580,834	(13,920)	566,914	(149,051)	417,863		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,213,338	170,975	546,546	1,930,859	(14,424)	1,916,435	(149,287)	1,767,148		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Park Ridge Care Center

#0039255

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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			21,122	21,122		21,122	37,399	58,521			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,682	13,682		13,682	72,350	86,032			32
33	Real Estate Taxes					14,424	14,424	113,333	127,757			33
34	Rent-Facility & Grounds			370,850	370,850		370,850	(370,850)				34
35	Rent-Equipment & Vehicles			7,641	7,641		7,641	2,638	10,279			35
36	Other (specify):*							6,808	6,808			36
37	TOTAL Ownership			413,295	413,295	14,424	427,719	(138,322)	289,397			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		39,613	204,114	243,727		243,727	(5,666)	238,061			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			25,185	25,185		25,185		25,185			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		39,613	229,299	268,912		268,912	(5,666)	263,246			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,213,338	210,588	1,189,140	2,613,066		2,613,066	(293,275)	2,319,791			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center

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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	(1,071)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(6,687)	30		9
10	Interest and Other Investment Income	(13,860)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(24)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(193,400)	21		24
25	Fund Raising, Advertising and Promotional	(5,859)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(7,600)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(29,330)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (257,831)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(35,444)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (35,444)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (293,275)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Park Ridge Care Center

ID# 0039255

Report Period Beginning: 01/01/09

Ending: 12/31/09

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	COPE Dues	\$ (856)	20	1
2	Bank Charges	(535)	21	2
3	Prior Period Office Expenses	(2,472)	21	3
4	Prior Period Radiology	(5,050)	39	4
5	Prior Period Oxygen	(174)	39	5
6	Prior Period R&M	(218)	06	6
7	Prior Period Nursing Supplies	(2,312)	10	7
8	Prior Period Dietary Supplies	(24)	01	8
9	Prior Period Laundry Expenses	(150)	04	9
10	Prior Period Legal	(246)	19	10
11	Prior Period Interest	(2,155)	32	11
12	Non-Allowable Legal	(700)	19	12
13	Building Company Amortization	(2,821)	31	13
14	Building Company Income Taxes	(500)	21	14
15	Building Company Accounting Fees	(11,972)	19	15
16	Building Company Trust Fees	(52)	21	16
17	Additional R&M	907	06	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	(29,330)		49

Park Ridge Care Center

ID# 0039255

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park Ridge Care Center# 0039255

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	(24)											(24)	1
2	Food Purchase	(24)											(24)	2
3	Housekeeping													3
4	Laundry	(150)											(150)	4
5	Heat and Other Utilities	(1,071)		472									(599)	5
6	Maintenance	689		2,403									3,092	6
7	Other (specify):*													7
8	TOTAL General Services	(580)		2,875									2,295	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(2,312)					(219)						(2,531)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(2,312)					(219)						(2,531)	16
	C. General Administration													
17	Administrative				14,025								14,025	17
18	Directors Fees													18
19	Professional Services	(12,918)	11,972	(35,657)									(36,603)	19
20	Fees, Subscriptions & Promotions	(6,715)		183									(6,532)	20
21	Clerical & General Office Expenses	(204,559)	552	19,505	3,135								(181,367)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			206									206	24
25	Other Admin. Staff Transportation			193									193	25
26	Insurance-Prop.Liab.Malpractice		54,856	542									55,398	26
27	Other (specify):*			3,788		1,841							5,629	27
28	TOTAL General Administration	(224,192)	67,380	(11,240)	17,160	1,841							(149,051)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(227,084)	67,380	(8,365)	17,160	1,841	(219)						(149,287)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Park Ridge Care Center# 0039255

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	(6,687)	42,788	1,298									37,399	30
31	Amortization of Pre-Op. & Org.	(2,821)	2,821											31
32	Interest	(16,015)	87,197	1,168									72,350	32
33	Real Estate Taxes		111,917	1,416									113,333	33
34	Rent-Facility & Grounds		(370,850)										(370,850)	34
35	Rent-Equipment & Vehicles			2,638									2,638	35
36	Other (specify):*		6,808										6,808	36
37	TOTAL Ownership	(25,523)	(119,319)	6,520									(138,322)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(5,224)					(442)						(5,666)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	(5,224)					(442)						(5,666)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(257,831)	(51,939)	(1,845)	17,160	1,841	(661)						(293,275)	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
See Attached		See Attached		See Attached		
				665 Busse Highway Limited Partnership		Building Co.

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	34 Rental Income	\$ 370,850	665 Busse Highway Limited Partnership	100.00%	\$	\$ (370,850)	1
2	V	32 Interest Income	1,310	665 Busse Highway Limited Partnership	100.00%		(1,310)	2
3	V	31 Amortization		665 Busse Highway Limited Partnership	100.00%	2,821	2,821	3
4	V	30 Depreciation		665 Busse Highway Limited Partnership	100.00%	42,788	42,788	4
5	V	36 MIP		665 Busse Highway Limited Partnership	100.00%	6,808	6,808	5
6	V	33 Real Estate Taxes		665 Busse Highway Limited Partnership	100.00%	111,917	111,917	6
7	V	26 Insurance		665 Busse Highway Limited Partnership	100.00%	54,856	54,856	7
8	V	32 Interest Expense- Greystone		665 Busse Highway Limited Partnership	100.00%	88,507	88,507	8
9	V	21 Income Taxes		665 Busse Highway Limited Partnership	100.00%	500	500	9
10	V	19 Accounting Fee		665 Busse Highway Limited Partnership	100.00%	11,972	11,972	10
11	V	21 Trust Fees		665 Busse Highway Limited Partnership	100.00%	52	52	11
12	V							12
13	V							13
14	Total		\$ 372,160			\$ 320,221	\$ * (51,939)	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	5 UTILITIES	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 472	\$	472	15
16	V	6 REPAIRS & MAINT.				2,403		2,403	16
17	V	19 PROFESSIONAL FEES				343		343	17
18	V	20 DUES AND SUBSCRIPTIONS				183		183	18
19	V	21 CLERICAL & GENERAL				19,505		19,505	19
20	V	24 SEMINARS AND TRAVEL				206		206	20
21	V	25 AUTO EXP.				193		193	21
22	V	26 INSURANCE				542		542	22
23	V	27 EMP.BEN. - GEN. ADMIN.				3,788		3,788	23
24	V	30 DEPRECIATION				1,298		1,298	24
25	V	32 INTEREST				1,168		1,168	25
26	V	33 REAL ESTATE TAXES				1,416		1,416	26
27	V	35 EQUIPMENT RENTAL				2,638		2,638	27
28	V								28
29	V	19 BOOKKEEPING	36,000					(36,000)	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		\$ 36,000			\$ 34,155	\$ *	(1,845)	39

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

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning: 01/01/09

Ending: 12/31/09

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	6 MAINT. CMP. - D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$		15
16	V	17 ADMIN. CMP. - M. MAUER				6,914	6,914	16
17	V	17 ADMIN. CMP. - M. AARON						17
18	V	17 ADMIN. CMP. - F. AARON						18
19	V	17 ADMIN. CMP. - S. GOLDSTEIN						19
20	V	17 ADMIN. CMP. - J. AARON						20
21	V	17 ADMIN. CMP. - S. KOPLIN						21
22	V	17 ADMIN. CMP. - D. MAGAFAS						22
23	V	17 ADMIN. CMP. - HOWARD ALTER						23
24	V	17 ADMIN. CMP. - NON-OWNER-V. DAVIS						24
25	V	17 ADMIN. CMP. - NON-OWNER -VAR.						25
26	V	17 ADMIN. CMP. - CFO NON OWNER				7,111	7,111	26
27	V	21 CLERICAL CMP. - S. AARON				3,135	3,135	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		\$			\$ 17,160	\$ * 17,160	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	7 EMP. BEN.- D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$		15
16	V	27 EMP. BEN.- M. MAUER				496	496	16
17	V	27 EMP. BEN.- M. AARON						17
18	V	27 EMP. BEN.- F. AARON						18
19	V	27 EMP. BEN.- S. GOLDSTEIN						19
20	V	27 EMP. BEN.- J. AARON						20
21	V	27 EMP. BEN.- S. KOPLIN						21
22	V	27 EMP. BEN.- D. MAGAFAS						22
23	V	27 EMP. BEN.- HOWARD ALTER						23
24	V	27 EMP. BEN.-V. DAVIS						24
25	V	27 EMP. BEN.- NON-OWNER						25
26	V	27 EMP. BEN.- CFO NON-OWNER				787	787	26
27	V	27 EMP. BEN. - S. AARON				558	558	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		\$			\$ 1,841	\$ * 1,841	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$		15
16	V	10 MEDICAL SUPPLIES	2,030	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	1,811	(219)	16
17	V	39 ANCILLARY EXPENSE	4,093	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	3,651	(442)	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		\$ 6,123			\$ 5,462	\$ * (661)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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		
15	V		\$			\$	\$	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		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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		
15	V		\$			\$	\$	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		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	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		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	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		\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	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		\$			\$	\$ *	39

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

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	Marshall Mauer	Relative	Administrative	0.00%	See Attached	1.42	2.84%	Alloc. Salary	\$ 6,914	17-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 6,914		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization DYNAMIC HEALTH CARE CONS.
 Street Address 3359 W. MAIN STREET
 City / State / Zip Code SKOKIE, IL. 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	393,498	11	\$ 13,322	\$ 13,929	\$ 472	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	393,498	11	67,883	13,929	2,403	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	393,498	11	9,699	13,929	343	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	393,498	11	5,183	13,929	183	4
5	21	CLERICAL & GENERAL	PATIENT DAYS	393,498	11	551,031	404,350	19,505	5
6	24	SEMINARS AND TRAVEL	PATIENT DAYS	393,498	11	5,810	13,929	206	6
7	25	AUTO EXP.	PATIENT DAYS	393,498	11	5,452	13,929	193	7
8	26	INSURANCE	PATIENT DAYS	393,498	11	15,305	13,929	542	8
9	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	393,498	11	107,005	13,929	3,788	9
10	30	DEPRECIATION	PATIENT DAYS	393,498	11	36,672	13,929	1,298	10
11	32	INTEREST	PATIENT DAYS	393,498	11	33,003	13,929	1,168	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	393,498	11	39,991	13,929	1,416	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	393,498	11	74,530	13,929	2,638	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					\$ 964,886	\$ 404,350	\$ 34,155	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 DYNAMIC HEALTH CARE CONS.
 Street Address 3359 W. MAIN STREET
 City / State / Zip Code SKOKIE, IL. 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

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	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	8	63,031	63,031		1
2	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	10	195,000	195,000	1	6,914
3	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	8	195,000	195,000		
4	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	5	106,000	106,000		
5	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	94,542	94,542		
6	17	ADMIN. CMP. - J. AARON	WGHTD. AVG. HOURS	40	1	2,657	2,657		
7	17	ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	30	3	73,196	73,196		
8	17	ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	50	8	160,425	160,425		
9	17	ADMIN. CMP. - HOWARD ALT	WGHTD. AVG. HOURS	40	1	12,000	12,000		
10	17	ADMIN. CMP. - NON-OWNER-V	WGHTD. AVG. HOURS	40	1	74,152	74,152		
11	17	ADMIN. CMP. - NON-OWNER -	WGHTD. AVG. HOURS	45	8	216,303	216,303		
12	17	ADMIN. CMP. - CFO NON OWN	WGHTD. AVG. HOURS	45	10	200,543	200,543	2	7,111
13	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	10	88,338	88,338	1	3,135
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25	TOTALS					\$ 1,481,187	\$ 1,481,188		\$ 17,160

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 DYNAMIC HEALTH CARE CONS.
 Street Address 3359 W. MAIN STREET
 City / State / Zip Code SKOKIE, IL. 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

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	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40	8	6,197			1
2	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	10	13,995	1	496	2
3	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	8	16,097			3
4	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	5	43,678			4
5	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	40	2	37,728			5
6	27	EMP. BEN.- J. AARON	WGHTD. AVG. HOURS	40	1				6
7	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS	30	3	25,540			7
8	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS	50	8	10,394			8
9	27	EMP. BEN.- HOWARD ALTER	WGHTD. AVG. HOURS	40	1	1,079			9
10	27	EMP. BEN.-V. DAVIS	WGHTD. AVG. HOURS	40	1	17,756			10
11	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	8	61,038			11
12	27	EMP. BEN.- CFO NON-OWNER	WGHTD. AVG. HOURS	45	10	22,185	2	787	12
13	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	10	15,719	1	558	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					\$ 271,406	\$	\$ 1,841	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization LINCOLN MEDICAL SUPPLIES, INC.
 Street Address 3359 W. MAIN STREET
 City / State / Zip Code SKOKIE, IL. 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1									1
2	10	MEDICAL SUPPLIES						1,811	2
3	39	ANCILLARY EXPENSE						3,651	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					\$	\$	\$ 5,462	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Park Ridge Care Center**

0039255 Report Period Beginning: **01/01/09** Ending: **12/31/09**

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Park Ridge Care Center

0039255

Report Period Beginning:

01/01/09

Ending:

12/31/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										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	Greystone	X	Mortgage			\$	\$ 1,351,263		\$ 88,507	1									
2	Allocation From Dynamic								1,168	2									
3										3									
4										4									
5	See Supplemental Schedule									5									
Working Capital																			
6	MB Financial	X	Line of Credit				150,649		11,527	6									
7										7									
8	See Supplemental Schedule									8									
9	TOTAL Facility Related					\$	\$ 1,501,912		\$ 101,202	9									
B. Non-Facility Related*																			
10	Interest Income	X							(13,860)	10									
11	Interest Income- Bldg. Co.	X							(1,310)	11									
12										12									
13	See Supplemental Schedule									13									
14	TOTAL Non-Facility Related					\$	\$		\$ (15,170)	14									
15	TOTALS (line 9+line14)					\$	\$ 1,501,912		\$ 86,032	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 6,808 Line # 36

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

SEE ACCOUNTANTS' COMPILATION REPORT

** 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

Park Ridge Care Center

0039255

Report Period Beginning:

01/01/09

Ending:

12/31/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	TOTAL Long-Term										7									
Working Capital																				
8										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	TOTAL Working Capital										14									
B. Non-Facility Related*																				
15										15										
16										16										
17										17										
18										18										
19										19										
20	TOTAL Non-Facility Related										20									

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

SEE ACCOUNTANTS' COMPILATION REPORT

** 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 Park Ridge Care Center

0039255

Report Period Beginning:

01/01/09

Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 13,300 B. General Construction Type: Exterior Brick Frame Steel Stud Number of Stories 1

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).

None

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	<u>Facility</u>			\$ <u>49,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 49,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/09

Ending:

12/31/09

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				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1994	8,310		20	416	416	5,536	9
10	Various		1995	33,691		20	1,685	1,685	21,542	10
11	Various		1997	21,547		20	1,077	1,077	12,682	11
12	Various		1998	18,893		20	946	946	10,616	12
13	Various		1999	7,527		20	378	378	3,942	13
14	Various		2000	70,948		20	3,509	3,509	33,370	14
15	Various		2001	5,250		20	412	412	3,470	15
16	Various		2002	6,602		20	423	423	3,424	16
17	Various		2003	24,130		20	1,964	1,964	15,344	17
18	Various		2004	3,490		20	175	175	950	18
19	Various		2005	2,457		20	179	179	777	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

*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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	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	Related Building Company (Pages 12F & 12G)	1,413,602	42,788		34,351	(8,437)	544,870	67
68	Related Party Allocations (Pages 12H & 12I)	15,702	403		449	46	7,328	68
69	Financial Statement Depreciation		14,447			(14,447)		69
70	TOTAL (lines 4 thru 69)	\$ 1,632,149	\$ 57,638		\$ 45,964	\$ (11,674)	\$ 663,851	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Park Ridge Care Center# 0039255

Report Period Beginning:

01/01/09

Ending:

12/31/09**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	
1	Totals from Page 12A, Carried Forward		\$ 1,632,149	\$ 57,638		\$ 45,964	\$ (11,674)	\$ 663,851	1
2	Camera System	2006	1,260		20	180	180	720	2
3	Air Conditioner	2006	619		20	124	124	443	3
4	Air Conditioner	2006	619		20	124	124	443	4
5	Roof Repair	2006	1,421		20	71	71	237	5
6	Roof Repair	2006	1,593		20	80	80	252	6
7	Remodel Dining Room	2006	1,705		20	85	85	298	7
8	Air Conditioner	2006	1,206		20	241	241	804	8
9	Roof Repair	2006	2,500		20	125	125	417	9
10	Roof Repair	2006	2,000		20	100	100	325	10
11	Roof Work	2006	2,000		20	100	100	317	11
12	One Pump	2007	1,251		20	125	125	355	12
13	Security Camera And Recorder	2007	2,265		20	324	324	917	13
14	One Heater And Ac	2007	462		20	39	39	99	14
15	One Heater And Ac	2007	648		20	54	54	139	15
16	Asphalt Driveway	2008	5,625		20	281	281	563	16
17	A/C Unit	2008	3,000		20	429	429	679	17
18	Roof Repair	2008	1,500		20	75	75	106	18
19	2 Heat/Cool Units	2008	1,269		20	63	63	90	19
20	New Phone System	2008	2,560		20	256	256	363	20
21	Ams New Phone System	2008	2,920		20	292	292	414	21
22	Awning/Screen Doors/Storm Window	2009	491		20	25	25	25	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,669,063	\$ 57,638		\$ 49,157	\$ (8,481)	\$ 671,857	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 1,669,063	\$ 57,638		\$ 49,157	\$ (8,481)	\$ 671,857	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	TOTAL (lines 1 thru 33)	\$ 1,669,063	\$ 57,638		\$ 49,157	\$ (8,481)	\$ 671,857	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 1,669,063	\$ 57,638		\$ 49,157	\$ (8,481)	\$ 671,857	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	TOTAL (lines 1 thru 33)	\$ 1,669,063	\$ 57,638		\$ 49,157	\$ (8,481)	\$ 671,857	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 1,669,063	\$ 57,638		\$ 49,157	\$ (8,481)	\$ 671,857	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	TOTAL (lines 1 thru 33)	\$ 1,669,063	\$ 57,638		\$ 49,157	\$ (8,481)	\$ 671,857	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	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	
1	Building Company Information								1
2	Buildings:								2
3	46 Beds	1961	1,323,000	34,223	39	33,923	(300)	544,182	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Flooring	2008	14,000	1,400	20	70	(1,330)	140	9
10	Nursing Station	2008	5,000	500	20	25	(475)	50	10
11	Nursing Station	2008	4,700	470	20	24	(447)	48	11
12	Econocare Call Light System	2008	12,011	1,201	20	60	(1,141)	120	12
13	Jacks & Son Asphalt Parking Lot	2008	16,033	1,603	20	80	(1,523)	160	13
14	Flooring	2009	15,578	1,558	20	78	(1,480)	78	14
15	Drop Ceiling & Lighting	2009	19,000	1,583	20	79	(1,504)	79	15
16	Roof Rubber Installation	2009	3,000	175	20	9	(166)	9	16
17	Asphalt Sealcoat & Stripe	2009	1,280	75	20	4	(71)	4	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12F & 12G lines 1 thru 33)	\$ 1,413,602	\$ 42,788		\$ 34,351	\$ (8,437)	\$ 544,870	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated From Dynamic	1993	15,702	403	35	449	46	7,328	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12H & 12I lines 1 thru 33)	\$ 15,702	\$ 403		\$ 449	\$ 46	\$ 7,328	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$ 58,610	\$ 6,675	\$ 8,197	\$ 1,522	10	\$ 45,693	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	149,243		20	20	10	149,208	73
74								74
75	TOTALS	\$ 207,853	\$ 6,675	\$ 8,217	\$ 1,542		\$ 194,901	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		Allocated From Dynamic	2009	\$ 7,009	\$ 895	\$ 1,147	\$ 252	5	\$ 1,466	76
77										77
78										78
79										79
80	TOTALS			\$ 7,009	\$ 895	\$ 1,147	\$ 252		\$ 1,466	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)	\$ 1,932,925	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 65,208	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 58,521	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (6,687)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 868,224	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? YES NO

If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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

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

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

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 3,762 Description: See Attached Schedule

(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	Facility	Honda	\$ 271.58	\$ 3,919	17
18	Allocated From Dynamic			2,598	18
19					19
20					20
21	TOTAL		\$ 271.58	\$ 6,517	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. _____/2009 \$ _____
13. _____/2010 \$ _____
14. _____/2011 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1	2		
		Drop-outs	Completed		
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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5	6	7	8		
			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 - 03	hrs	\$		\$	92,998	\$			\$	92,998	1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				1,089					1,089	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	39 - 03	hrs				108,427					108,427	4	
5	Physician Care		visits										5	
6	Dental Care		visits										6	
7	Work Related Program		hrs										7	
8	Habilitation		hrs										8	
9	Pharmacy	39 - 02	# of prescrpts				(108)		30,171			30,063	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Other (specify):												12	
13	Other (specify): <u>See Supplemental</u>						1,708		9,442			11,150	13	
14	TOTAL			\$				\$	204,114	\$	39,613	\$	243,727	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning: 01/01/09

Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09 (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	\$ 356,231	\$ 363,488	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	512,355	512,355	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,617	45,219	6
7	Other Prepaid Expenses	3,591	3,591	7
8	Accounts Receivable (owners or related parties)	81,390	333,508	8
9	Other(specify): <u>See Attached Schedule</u>	13,650	355,820	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 982,834	\$ 1,613,981	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		49,000	13
14	Buildings, at Historical Cost		1,323,000	14
15	Leasehold Improvements, at Historical Cost	219,417	310,019	15
16	Equipment, at Historical Cost	116,035	214,035	16
17	Accumulated Depreciation (book methods)	(266,416)	(919,140)	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): <u>See Attached Schedule</u>		50,625	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 69,036	\$ 1,027,539	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,051,870	\$ 2,641,520	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 52,288	\$ 52,288	26
27	Officer's Accounts Payable	44,465	44,465	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	150,649	150,649	29
30	Accrued Salaries Payable	143,075	143,075	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,869	5,869	31
32	Accrued Real Estate Taxes(Sch.IX-B)		118,000	32
33	Accrued Interest Payable		7,319	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>		81,390	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 396,346	\$ 603,055	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,351,263	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>	45,625	45,625	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 45,625	\$ 1,396,888	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 441,971	\$ 1,999,943	46
47	TOTAL EQUITY(page 18, line 24)	\$ 609,899	\$ 641,577	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,051,870	\$ 2,641,520	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 783,117	1
2	Restatements (describe):		2
3	Rounding Adjustment	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 783,119	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	36,780	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	(210,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (173,220)	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)	\$ 609,899	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center# 0039255Report Period Beginning: 01/01/09Ending: 12/31/09

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	\$ 2,325,022	1
2	Discounts and Allowances for all Levels	(561,585)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,763,437	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	665,280	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 665,280	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	46,206	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,659	19
20	Radiology and X-Ray		20
21	Other Medical Services	6,327	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 55,192	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	13,860	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 13,860	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	152,077	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 152,077	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,649,846	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	510,677	31
32	Health Care	839,348	32
33	General Administration	580,834	33
B. Capital Expense			
34	Ownership	413,295	34
C. Ancillary Expense			
35	Special Cost Centers	243,727	35
36	Provider Participation Fee	25,185	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,613,066	40
41	Income before Income Taxes (line 30 minus line 40)**	36,780	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 36,780	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

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

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

Facility Name & ID Number **Park Ridge Care Center**

0039255

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	2,093	2,391	\$ 89,101	\$ 37.27	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,597	7,823	254,071	32.48	3
4	Licensed Practical Nurses	803	803	20,225	25.19	4
5	CNAs & Orderlies	25,815	28,621	380,331	13.29	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,230	2,511	49,265	19.62	13
14	Head Cook	3,879	4,407	58,434	13.26	14
15	Cook Helpers/Assistants	7,087	7,645	75,868	9.92	15
16	Dishwashers					16
17	Maintenance Workers	1,997	2,137	49,211	23.03	17
18	Housekeepers	8,313	8,992	92,101	10.24	18
19	Laundry	2,090	2,300	27,672	12.03	19
20	Administrator	2,086	2,206	95,740	43.40	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,513	1,584	18,667	11.78	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	156	208	2,652	12.75	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	65,659	71,628	\$ 1,213,338 *	\$ 16.94	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			35	
36	Medical Director	116	5,800	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	18	900	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	25	1,281	11-03	44
45	Social Service Consultant	52	3,002	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	211	\$ 10,983		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	472	\$ 18,221	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	472	\$ 18,221		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center

0039255

Report Period Beginning: 01/01/09

Ending: 12/31/09

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	
Rob Weisz	Administrator	0.00%	\$ 95,740	Workers' Compensation Insurance	\$ 24,330	IDPH License Fee	\$	
				Unemployment Compensation Insurance	5,681	Advertising: Employee Recruitment	30	
				FICA Taxes	91,579	Health Care Worker Background Check	300	
				Employee Health Insurance	13,869	(Indicate # of checks performed <u>30</u>)		
				Employee Meals	504	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Permits	2,243	
				Other Employee Benefits	3,189	Dues & Subscriptions	2,981	
						Advertising & Promotions	5,859	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 95,740			Allocation From Dynamic	183	
(List each licensed administrator separately.)								
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)				
Description			Amount			Less: Public Relations Expense	()	
			\$			Non-allowable advertising	(5,859)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$			TOTAL (agree to Sch. V, line 20, col. 8)		
(Attach a copy of any management service agreement)							\$ 5,737	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Frost, Ruttenberg & Rothblatt	Accounting		\$ 13,339			\$	Out-of-State Travel	\$
Skidelsky & Associates	Real Estate Appraisal Fee		14,424					
Much Shelist	Legal		700					
Personnel Planners	Unemployment Consult		330				In-State Travel	
Hanson Associates	Architecture		530					
Health Data Systems, Inc	Data Processing		4,530					
Dynamic HC Consultants	Bookkeeping		36,000					
Prior Period Legal Expense	Adjusted on Page 5A		246				Seminar Expense	1,174
							Allocation From Dynamic	206
TOTAL (agree to Schedule V, line 19, column 3)			\$ 70,099	TOTAL		\$	Entertainment Expense	()
(If total legal fees exceed \$5,000, attach copy of invoices.)							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 1,380

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**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	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center# 0039255Report Period Beginning: 01/01/09Ending: 12/31/09**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ILCLTC \$2,622
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 21,014 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 25,185
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. \$ 504 Has any meal income been offset against related costs? No 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? 100 % Ln14
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? No
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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.