



Facility Name & ID Number West Ridge Rehabilitation Center

# 0049817 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	164	Skilled (SNF)	164	59,860	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	164	TOTALS	164	59,860	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	8,703	1,658	4,506	14,867	8
9	SNF/PED					9
10	ICF	18,738	1,864		20,602	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,441	3,522	4,506	35,469	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.25%

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 11/01/2007

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 11/01/2007 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 164 and days of care provided 3,580

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

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

Facility Name & ID Number West Ridge Rehabilitation Center # 0049817 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
	<b>A. General Services</b>										
1	Dietary	317,077	43,999	9,085	370,161		370,161	(607)	369,554		1
2	Food Purchase		271,922		271,922	(17,374)	254,548	(269)	254,279		2
3	Housekeeping	182,007	33,853		215,860		215,860	(7)	215,853		3
4	Laundry	65,856	23,938		89,794		89,794	(227)	89,567		4
5	Heat and Other Utilities			166,751	166,751		166,751	(4,226)	162,525		5
6	Maintenance	66,654	13,689	140,976	221,319		221,319	(3,211)	218,108		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	631,594	387,401	316,812	1,335,807	(17,374)	1,318,433	(8,548)	1,309,885		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	2,450,336	183,476	54,686	2,688,498		2,688,498	(11,830)	2,676,668		10
10a	Therapy	46,812		8,322	55,134		55,134		55,134		10a
11	Activities	134,473	13,251	896	148,620		148,620		148,620		11
12	Social Services	87,243		2,006	89,249		89,249		89,249		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,718,864	196,727	74,910	2,990,501		2,990,501	(11,830)	2,978,671		16
	<b>C. General Administration</b>										
17	Administrative	51,882		173,423	225,305		225,305	13,523	238,828		17
18	Directors Fees										18
19	Professional Services			144,395	144,395		144,395	(105,426)	38,969		19
20	Dues, Fees, Subscriptions & Promotions			17,283	17,283		17,283	(8,065)	9,218		20
21	Clerical & General Office Expenses	152,054	30,798	281,884	464,736		464,736	(212,030)	252,706		21
22	Employee Benefits & Payroll Taxes			560,503	560,503	17,374	577,877		577,877		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,180	3,180		3,180	(450)	2,730		24
25	Other Admin. Staff Transportation			13,941	13,941		13,941		13,941		25
26	Insurance-Prop.Liab.Malpractice			141,592	141,592		141,592	22	141,614		26
27	Other (specify):*							10,531	10,531		27
28	<b>TOTAL General Administration</b>	203,936	30,798	1,336,201	1,570,935	17,374	1,588,309	(301,895)	1,286,414		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,554,394	614,926	1,727,923	5,897,243		5,897,243	(322,273)	5,574,970		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.

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			68,759	68,759		68,759	280,955	349,714			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			233,501	233,501		233,501	379,896	613,397			32
33	Real Estate Taxes							1,111	1,111			33
34	Rent-Facility & Grounds			390,000	390,000		390,000	(390,000)				34
35	Rent-Equipment & Vehicles			4,384	4,384		4,384		4,384			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			696,644	696,644		696,644	271,962	968,606			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		157,929	366,480	524,409		524,409	(1,018)	523,391			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			89,790	89,790		89,790		89,790			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		157,929	456,270	614,199		614,199	(1,018)	613,181			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,554,394	772,855	2,880,837	7,208,086		7,208,086	(51,328)	7,156,758			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

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,597)	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	(187,203)	30		9
10	Interest and Other Investment Income	(16,683)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(269)	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	(261,749)	21		24
25	Fund Raising, Advertising and Promotional	(8,065)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(54,274)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (532,839)		\$	30

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	481,511		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 481,511		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (51,328)		37

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

West Ridge Rehabilitation Center

ID# 0049817

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Fees	\$ (4,320)	21	1
2	Theft & Damage	(895)	21	2
3	Capitalized R&M	(8,322)	06	3
4	Fees - Building Co.	(250)	21	4
5	Amortization - Building Co.	(23,095)	36	5
6	Professional Fees - Building Co.	(20,957)	19	6
7	Non Allowable Legal Fees	(989)	19	7
8	Non Allowable Seminar	(450)	24	8
9	Additional R&M	5,005	06	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(54,274)		49

West Ridge Rehabilitation Center

ID# 0049817

Report Period Beginning: 01/01/09

Ending: 12/31/09

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 West Ridge Rehabilitation Center# 0049817

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				(607)								(607)	1
2	Food Purchase	(269)											(269)	2
3	Housekeeping				(7)								(7)	3
4	Laundry				(227)								(227)	4
5	Heat and Other Utilities	(4,597)		371									(4,226)	5
6	Maintenance	(3,317)		106									(3,211)	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(8,183)</b>		<b>477</b>	<b>(841)</b>								<b>(8,548)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records				(11,830)								(11,830)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>				<b>(11,830)</b>								<b>(11,830)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			13,523									13,523	17
18	Directors Fees													18
19	Professional Services	(21,946)	20,957	(104,437)									(105,426)	19
20	Fees, Subscriptions & Promotions	(8,065)											(8,065)	20
21	Clerical & General Office Expenses	(267,214)	250	54,934									(212,030)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(450)											(450)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			22									22	26
27	Other (specify):*			10,531									10,531	27
28	<b>TOTAL General Administration</b>	<b>(297,675)</b>	<b>21,207</b>	<b>(25,427)</b>									<b>(301,895)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(305,859)</b>	<b>21,207</b>	<b>(24,950)</b>	<b>(12,671)</b>								<b>(322,273)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number West Ridge Rehabilitation Center# 0049817

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)	
	<b>D. Ownership</b>													
30	Depreciation	(187,203)	466,382	1,776									280,955	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(16,683)	395,417	1,162									379,896	32
33	Real Estate Taxes			1,111									1,111	33
34	Rent-Facility & Grounds		(390,000)										(390,000)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(23,095)	23,095											36
37	<b>TOTAL Ownership</b>	<b>(226,981)</b>	<b>494,894</b>	<b>4,049</b>									<b>271,962</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(1,018)								(1,018)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>				<b>(1,018)</b>								<b>(1,018)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(532,839)</b>	<b>516,101</b>	<b>(20,901)</b>	<b>(13,689)</b>								<b>(51,328)</b>	<b>45</b>

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				West Ridge Properties, LLC		Building Company

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rental Income	\$ 390,000	West Ridge Properties, LLC	100.00%	\$	(390,000)	1
2	V	21 Fees		West Ridge Properties, LLC	100.00%	250	250	2
3	V	36 Amortization Expense		West Ridge Properties, LLC	100.00%	23,095	23,095	3
4	V	30 Depreciation Expense		West Ridge Properties, LLC	100.00%	466,382	466,382	4
5	V	32 Interest Expense		West Ridge Properties, LLC	100.00%	395,417	395,417	5
6	V	19 Professional Fees		West Ridge Properties, LLC	100.00%	20,957	20,957	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 390,000			\$ 906,101	\$ * 516,101	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	17 ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	13,523	\$	13,523	15
16	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	434		434	16
17	V	21 CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	54,923		54,923	17
18	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	10,531		10,531	18
19	V								19
20	V								20
21	V	19 PROFESSIONAL FEES	104,880	S.I.R. MANAGEMENT, INC.	100.00%			(104,880)	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V	5 UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	371		371	27
28	V	6 REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	106		106	28
29	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	9		9	29
30	V	21 CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	11		11	30
31	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	22		22	31
32	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	1,776		1,776	32
33	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	1,162		1,162	33
34	V	33 REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	1,111		1,111	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 104,880			\$ 83,979	\$ *	(20,901)	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	1 Dietary	\$ 6,614	Xcel Supply, LLC	100.00%	\$ 6,007	\$ (607)
16	V	3 Housekeeping	78	Xcel Supply, LLC	100.00%	71	(7)
17	V	4 Laundry	2,468	Xcel Supply, LLC	100.00%	2,242	(227)
18	V	6 Repairs & Maintenance		Xcel Supply, LLC	100.00%		
19	V	10 Nursing	128,821	Xcel Supply, LLC	100.00%	116,992	(11,830)
20	V	11 Activities		Xcel Supply, LLC	100.00%		
21	V	12 Social Service		Xcel Supply, LLC	100.00%		
22	V	20 Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%		
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%		
24	V	22 Employee Benefits		Xcel Supply, LLC	100.00%		
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%		
26	V	39 Ancillary	11,080	Xcel Supply, LLC	100.00%	10,063	(1,018)
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	<b>Total</b>		\$ 149,062			\$ 135,374	\$ * (13,689)

\* 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	22 Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 91,258	\$ 91,258	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	91,258	CCS Employee Benefits Group	100.00%		(91,258)	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		\$ 91,258			\$ 91,258	\$ *	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name & ID Number West Ridge Rehabilitation Center

# 0049817

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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

West Ridge Rehabilitation Center

# 0049817

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	Tom Winter	Shareholder	Administrative	1.22%	See Attached	3.47	5.78%	Alloc. Salary	\$ 11,283	17-7	1
2										17-7	2
3	Leo Feigenbaum	Relative	Administrator	None	See Attached	55.00	91.67%	Mgmt. Fee	172,500	17-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 183,783		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 West Ridge Rehabilitation Center

# 0049817

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 S.I.R. MANAGEMENT, INC.  
 Street Address 6840 N. LINCOLN  
 City / State / Zip Code LINCOLNWOOD, IL. 60712  
 Phone Number ( 847) 675 -7979  
 Fax Number ( 847) 675 -0555

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	ADMINISTRATIVE	PATIENT DAYS	841,652	13	320,892	320,892	35,469	13,523	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	841,652	13	10,309		35,469	434	2
3	21	CLERICAL & GENERAL	PATIENT DAYS	841,652	13	1,303,285	68,837	35,469	54,923	3
4	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	841,652	13	249,900		35,469	10,531	4
5										5
6										6
7										7
8										8
9										9
10										10
11	5	UTILITIES	ALLOCATED SQ FT	12,879	13	28,260		169	371	11
12	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	13	8,091		169	106	12
13	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	13	689		169	9	13
14	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	13	822		169	11	14
15	26	INSURANCE	ALLOCATED SQ FT	12,879	13	1,678		169	22	15
16	30	DEPRECIATION	ALLOCATED SQ FT	12,879	13	135,367		169	1,776	16
17	32	INTEREST	ALLOCATED SQ FT	12,879	13	88,526		169	1,162	17
18	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	13	84,702		169	1,111	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,232,521	\$ 389,729	\$	83,979	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number West Ridge Rehabilitation Center

# 0049817

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Xcel Supply, LLC

Street Address

2201 Main Street

City / State / Zip Code

Evanston, IL 60202

Phone Number

( 847)328-7600

Fax Number

( 847)328-7615

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	Dietary						6,007	1
2	3	Housekeeping						71	2
3	4	Laundry						2,242	3
4	6	Repairs & Maintenance							4
5	10	Nursing						116,992	5
6	11	Activities							6
7	12	Social Service							7
8	20	Dues, Fees And Subscriptions							8
9	21	Office And Clerical							9
10	22	Employee Benefits							10
11	24	Seminars & Education							11
12	39	Ancillary						10,063	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							135,374	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number West Ridge Rehabilitation Center

# 0049817

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization CCS Employee Benefits Group, Inc.  
 Street Address 2201 Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847)905-4000  
 Fax Number ( 847)905-4040

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	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 91,258	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				\$	\$		\$ 91,258	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number West Ridge Rehabilitation Center

# 0049817

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 West Ridge Rehabilitation Center

# 0049817

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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number West Ridge Rehabilitation Center

# 0049817

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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number West Ridge Rehabilitation Center

# 0049817

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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number West Ridge Rehabilitation Center

# 0049817

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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number West Ridge Rehabilitation Center

# 0049817

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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

West Ridge Rehabilitation Center

# 0049817

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		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
	<b>A. Directly Facility Related</b>																			
	<b>Long-Term</b>																			
1	First Commercial Bank		X	Mortgage			\$	\$ 6,000,000	12/20/2013	6.5000	\$ 395,417	1								
2												2								
3												3								
4												4								
5	See Supplemental Schedule											5								
	<b>Working Capital</b>																			
6	Midwest Bank		X	Line of Credit				2,780,244			233,501	6								
7	S.I.R. Management Alloc.		X								1,162	7								
8	See Supplemental Schedule											8								
9	TOTAL Facility Related						\$	\$ 8,780,244			\$ 630,080	9								
	<b>B. Non-Facility Related*</b>																			
10	Interest Income		X								(16,683)	10								
11												11								
12												12								
13	See Supplemental Schedule											13								
14	TOTAL Non-Facility Related						\$	\$			\$ (16,683)	14								
15	TOTALS (line 9+line14)						\$	\$ 8,780,244			\$ 613,397	15								

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

\* 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 West Ridge Rehabilitation Center

# 0049817

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		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
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
6											6							
7	<b>TOTAL Long-Term</b>										7							
<b>Working Capital</b>																		
8						\$	\$			\$	8							
9											9							
10											10							
11											11							
12											12							
13											13							
14	<b>TOTAL Working Capital</b>										14							
<b>B. Non-Facility Related*</b>																		
15						\$	\$			\$	15							
16											16							
17											17							
18											18							
19											19							
20	<b>TOTAL Non-Facility Related</b>										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 West Ridge Rehabilitation Center

# 0049817

Report Period Beginning:

01/01/09

Ending:

12/31/09

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 50,536 B. General Construction Type: Exterior Brick Frame Wood 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>2007</u>	<u>\$ 246,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 246,000</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number West Ridge Rehabilitation Center

# 0049817

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
	<b>Improvement Type**</b>										
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

\*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 West Ridge Rehabilitation Center

# 0049817

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)	7,134,000	201,005		182,923	(18,082)	373,468	67
68	Related Party Allocations (Pages 12H & 12I)	19,288	863		681	(182)	6,911	68
69	Financial Statement Depreciation		68,759			(68,759)		69
70	TOTAL (lines 4 thru 69)	\$ 7,153,288	\$ 270,627		\$ 183,604	\$ (87,023)	\$ 380,379	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number West Ridge Rehabilitation Center

# 0049817

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	<b>Totals from Page 12A, Carried Forward</b>		\$ 7,153,288	\$ 270,627		\$ 183,604	\$ (87,023)	\$ 380,379	1
2	Surveillance Equipment	2008	2,610		20	522	522	740	2
3	Flooring	2008	39,270		20	2,618	2,618	3,709	3
4	Flooring And Bathrooms	2008	87,472		20	5,831	5,831	7,775	4
5	Window Treatments / Cornice	2008	67,292		20	13,458	13,458	17,945	5
6	Window Treatments / Cornice	2008	1,526		20	305	305	407	6
7	Window Treatments / Cornice	2008	2,597		20	519	519	693	7
8	Painting Doors	2008	6,720		20	672	672	1,288	8
9	Nurse Station	2008	23,730		20	4,746	4,746	5,933	9
10	Painting	2008	67,000		20	3,350	3,350	5,025	10
11	Water Heater	2008	5,300		20	530	530	1,016	11
12	Hvac Exhaust Fan	2008	3,200		20	320	320	613	12
13	Flooring	2008	37,516		20	2,501	2,501	4,585	13
14	Light Fixtures	2008	1,395		20	279	279	512	14
15	Electrical Work	2008	3,859		20	386	386	707	15
16	Flooring	2008	15,134		20	1,009	1,009	1,766	16
17	4Th Flr-Ceiling Tiles, Remove Wallpaper, Paint, Door Frames	2008	47,770		20	3,185	3,185	5,042	17
18	Flooring	2008	2,078		20	139	139	208	18
19	Balcony Work	2008	11,900		20	1,190	1,190	1,785	19
20	Electrical Work	2008	2,610		20	261	261	326	20
21	Renovation - Paint, Varnish	2008	41,938		20	4,194	4,194	5,242	21
22	Painting & Sign	2008	2,865		20	143	143	215	22
23	Booster Heater	2008	2,843		20	142	142	190	23
24	Wiring And Cable	2009	11,581		20	97	97	97	24
25	Sprinkler System Repair	2009	2,513		20	126	126	126	25
26	Boiler Work	2009	2,577		20	129	129	129	26
27	Fire Alarm Repair/Smoke Detector	2009	3,233		20	162	162	162	27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,649,816	\$ 270,627		\$ 230,417	\$ (40,210)	\$ 446,614	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number West Ridge Rehabilitation Center

# 0049817

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		\$ 7,649,816	\$ 270,627		\$ 230,417	\$ (40,210)	\$ 446,614	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)	\$ 7,649,816	\$ 270,627		\$ 230,417	\$ (40,210)	\$ 446,614	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number West Ridge Rehabilitation Center

# 0049817

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		\$ 7,649,816	\$ 270,627		\$ 230,417	\$ (40,210)	\$ 446,614	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)	\$ 7,649,816	\$ 270,627		\$ 230,417	\$ (40,210)	\$ 446,614	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number West Ridge Rehabilitation Center

# 0049817

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		\$ 7,649,816	\$ 270,627		\$ 230,417	\$ (40,210)	\$ 446,614
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 7,649,816	\$ 270,627		\$ 230,417	\$ (40,210)	\$ 446,614

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number West Ridge Rehabilitation Center

# 0049817

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	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	<b>Building Company Information</b>								1
2	<b>Buildings:</b>								2
3		1973	7,134,000	201,005	39	182,923	(18,082)	373,468	3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								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 West Ridge Rehabilitation Center

# 0049817

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)	\$ 7,134,000	\$ 201,005		\$ 182,923	\$ (18,082)	\$ 373,468	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number West Ridge Rehabilitation Center

# 0049817

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	<b>Related Party Information</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3	<b>S.I.R. Properties - S.I.R. Management Allocation</b>	1993	5,940	189	35	170	(19)	2,800	3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	<b>S.I.R. Management Allocation</b>	1993	1,506	42	20	75	33	1,269	9
10	<b>S.I.R. Management Allocation</b>	1994	5		20			5	10
11	<b>S.I.R. Management Allocation</b>	1995	34		20	2	2	25	11
12	<b>S.I.R. Management Allocation</b>	1997	2,314	52	20	116	64	1,482	12
13	<b>S.I.R. Management Allocation</b>	1999	182		20	9	9	93	13
14	<b>S.I.R. Management Allocation</b>	2000	215		20	11	11	102	14
15	<b>S.I.R. Management Allocation</b>	2007	690	123	20	35	(88)	76	15
16	<b>S.I.R. Management Allocation</b>	2008	1,902	190	20	120	(70)	221	16
17	<b>S.I.R. Management Allocation</b>	2009	4,727	9	20	58	49	58	17
18									18
19	<b>S.I.R. Properties - S.I.R. Management Allocation</b>	2009	357	204	20	14	(190)	14	19
20	<b>S.I.R. Properties - S.I.R. Management Allocation</b>	2007	104	15	20	5	(10)	16	20
21	<b>S.I.R. Properties - S.I.R. Management Allocation</b>	2002	24		20	1	1	9	21
22	<b>S.I.R. Properties - S.I.R. Management Allocation</b>	1999	753	38	20	38		395	22
23	<b>S.I.R. Properties - S.I.R. Management Allocation</b>	1998	360		20	18	18	207	23
24	<b>S.I.R. Properties - S.I.R. Management Allocation</b>	1997	22		20	1	1	15	24
25	<b>S.I.R. Properties - S.I.R. Management Allocation</b>	1994	57	1	20	3	2	44	25
26	<b>S.I.R. Properties - S.I.R. Management Allocation</b>	1993	96		20	5	5	80	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 West Ridge Rehabilitation Center

# 0049817

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)		\$ 19,288	\$ 863		\$ 681	\$ (182)	\$ 6,911	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number West Ridge Rehabilitation Center

# 0049817

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	\$ 993,999	\$ 266,263	\$ 118,228	\$ (148,035)	10	\$ 217,605	71
72	Current Year Purchases	13,177	28	1,023	995	10	1,023	72
73	Fully Depreciated Assets	4,972		47	47	10	4,972	73
74								74
75	TOTALS	\$ 1,012,148	\$ 266,291	\$ 119,298	\$ (146,993)		\$ 223,600	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)	\$ 8,907,964	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 536,918	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 349,715	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (187,203)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 670,214	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.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

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

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: \$ 4,384 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			\$	\$	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. \_\_\_\_\_/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 Drop-outs	2 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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

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

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
  - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- 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		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs				\$ 60,322				\$ 60,322	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				45,877				45,877	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				260,281				260,281	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					118,091			118,091	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): <b>See Supplemental</b>							39,838			39,838	13
14	<b>TOTAL</b>				\$		\$ 366,480	\$ 157,929		\$	524,409	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 West Ridge Rehabilitation Center# 0049817Report Period Beginning: 01/01/09Ending: 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*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 4,683	\$ 78,587	1
2	Cash-Patient Deposits	26,431	26,431	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,599,772	1,599,772	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	49,532	49,532	6
7	Other Prepaid Expenses	4,384	4,384	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,684,802	\$ 1,758,706	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		246,000	13
14	Buildings, at Historical Cost		5,130,319	14
15	Leasehold Improvements, at Historical Cost	466,911	570,834	15
16	Equipment, at Historical Cost	197,247	2,031,022	16
17	Accumulated Depreciation (book methods)	(102,377)	(1,038,525)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		30,175	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(6,286)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>		935,741	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 561,781	\$ 7,899,280	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,246,583	\$ 9,657,986	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 274,336	\$ 274,336	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,517	26,517	28
29	Short-Term Notes Payable	2,780,244	2,780,244	29
30	Accrued Salaries Payable	332,339	332,339	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,774	16,774	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		10,833	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>	1,500,000	1,559,860	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 4,930,210	\$ 5,000,903	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,000,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 6,000,000	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,930,210	\$ 11,000,903	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (2,683,627)	\$ (1,342,917)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,246,583	\$ 9,657,986	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(1,868,177)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Rounding</b>	<b>3</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(1,868,174)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(1,023,453)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>Partners Capital</b>	<b>208,000</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(815,453)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(2,683,627)</b>	<b>24</b> *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number West Ridge Rehabilitation Center

# 0049817

Report Period Beginning: 01/01/09

Ending: 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,416,195	1
2	Discounts and Allowances for all Levels	(302,445)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,113,750	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	812,351	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 812,351	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	112,276	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,469	19
20	Radiology and X-Ray	523	20
21	Other Medical Services	18,280	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 141,548	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	16,683	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 16,683	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	100,301	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 100,301	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,184,633	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,335,807	31
32	Health Care	2,990,501	32
33	General Administration	1,570,935	33
<b>B. Capital Expense</b>			
34	Ownership	696,644	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	524,409	35
36	Provider Participation Fee	89,790	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,208,086	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(1,023,453)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (1,023,453)	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 **West Ridge Rehabilitation Center**

# **0049817**

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	1,949	2,086	\$ 95,357	\$ 45.71	1
2	Assistant Director of Nursing					2
3	Registered Nurses	29,926	33,035	1,045,519	31.65	3
4	Licensed Practical Nurses	8,154	8,811	222,759	25.28	4
5	CNAs & Orderlies	62,126	67,592	938,042	13.88	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,594	2,775	46,812	16.87	8
9	Activity Director	2,029	2,247	52,013	23.15	9
10	Activity Assistants	6,928	7,196	82,460	11.46	10
11	Social Service Workers	3,873	4,302	87,243	20.28	11
12	Dietician					12
13	Food Service Supervisor	1,997	2,142	36,409	17.00	13
14	Head Cook	385	385	15,417	40.04	14
15	Cook Helpers/Assistants	21,325	23,422	265,251	11.32	15
16	Dishwashers					16
17	Maintenance Workers	4,137	4,282	66,654	15.57	17
18	Housekeepers	13,789	15,219	182,007	11.96	18
19	Laundry	4,665	5,025	65,856	13.11	19
20	Administrator					20
21	Assistant Administrator	2,120	2,434	51,882	21.32	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,648	11,821	152,054	12.86	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	5,214	5,718	148,659	26.00	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	181,859	198,492	\$ 3,554,394 *	\$ 17.91	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	176	\$ 9,085	01-03	35
36	Medical Director	Monthly	9,000	09-03	36
37	Medical Records Consultant	Monthly	1,536	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	205	10-03	39
40	Physical Therapy Consultant	Monthly	4,864	10a-03	40
41	Occupational Therapy Consultant	Monthly	3,458	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	896	11-03	44
45	Social Service Consultant	30	2,006	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	218	\$ 31,050		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	8	\$ 448	10-03	50
51	Licensed Practical Nurses	1,632	43,550	10-03	51
52	Certified Nurse Assistants/Aides	435	8,947	10-03	52
53	TOTAL (lines 50 - 52)	2,075	\$ 52,945		53

SEE ACCOUNTANTS' COMPILATION REPORT



**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	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number West Ridge Rehabilitation Center# 0049817Report 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. Illinois Assoc. of Healthcare \$1,968
- (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. \$ 37,580 Line 10
- (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. \$ 89,790  
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? N/A 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. \$ 17,374 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
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? 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? Np**  
**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: NA
- (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.