FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0045815

Facility Name: Chicago Ridge Nursing Center

Address: 10602 Southwest Highway (Number) Chicago Ridge (City) 60415 (Zip Code)

County: Cook

Telephone Number: (773) 252-3208 **Fax #** (773) 252-3688

HFS ID Number:

Date of Initial License for Current Owners: 11/01/2001

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Sanford B Alper **Telephone Number:** (847) 580-4100
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Sanford B Alper, Principal
(Firm Name & Address) Kessler Orlean Silver & Company, P.C., 1101 Lake Cook Road, Suite C, Deerfield IL 60015
(Telephone) (847) 580-4100 Fax # (847) 580-4199

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	231	Skilled (SNF)	231	84,315	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	231	TOTALS	231	84,315	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	72,528	1,784	5,329	79,641	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	72,528	1,784	5,329	79,641	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.46%

D. How many bed-hold days during this year were paid by the Department?
1,714 (Do not include bed-hold days in Section B.)

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

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/2001

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/2001 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 38 and days of care provided 4,064

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	299,952	25,023	9,853	334,828		334,828	363,748	698,576			1
2	Food Purchase		322,097		322,097		322,097	(608)	321,489			2
3	Housekeeping	256,172	28,096		284,268		284,268		284,268			3
4	Laundry	91,008	8,077		99,085		99,085		99,085			4
5	Heat and Other Utilities			193,353	193,353		193,353	5,109	198,462			5
6	Maintenance	29,780	41,888		71,668		71,668	210,358	282,026			6
7	Other (specify):* Attached Schedule			23,951	23,951		23,951	193	24,144			7
8	**TOTAL General Services**	676,912	425,181	227,157	1,329,250		1,329,250	578,800	1,908,050			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,823,380	79,004	268,317	2,170,701		2,170,701		2,170,701			10
10a	Therapy											10a
11	Activities	96,092	767		96,859		96,859		96,859			11
12	Social Services	237,433	51,600	5,570	294,603		294,603		294,603			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,156,905	131,371	273,887	2,562,163		2,562,163		2,562,163			16
	C. General Administration											
17	Administrative	52,380		1,413,956	1,466,336		1,466,336	(795,733)	670,603			17
18	Directors Fees											18
19	Professional Services			55,190	55,190		55,190	53,801	108,991			19
20	Dues, Fees, Subscriptions & Promotions			24,566	24,566		24,566	(9,140)	15,426			20
21	Clerical & General Office Expenses	52,821		39,326	92,147		92,147	149,555	241,702			21
22	Employee Benefits & Payroll Taxes			357,211	357,211		357,211	67,977	425,188			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,475	2,475		2,475		2,475			24
25	Other Admin. Staff Transportation			80	80		80	375	455			25
26	Insurance-Prop.Liab.Malpractice							212,167	212,167			26
27	Other (specify):*											27
28	**TOTAL General Administration**	105,201		1,892,804	1,998,005		1,998,005	(320,998)	1,677,007			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,939,018	556,552	2,393,848	5,889,418		5,889,418	257,802	6,147,220			29

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

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

Facility Name & ID Number Chicago Ridge Nursing Center #0045815 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			23,190	23,190		23,190	436,446	459,636			30
31	Amortization of Pre-Op. & Org.							5,873	5,873			31
32	Interest			10,048	10,048		10,048	776,174	786,222			32
33	Real Estate Taxes							203,278	203,278			33
34	Rent-Facility & Grounds			1,860,000	1,860,000		1,860,000	(1,860,000)				34
35	Rent-Equipment & Vehicles			2,717	2,717		2,717	707	3,424			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,895,955	1,895,955		1,895,955	(437,522)	1,458,433			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		285,879	204,803	490,682		490,682		490,682			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			126,473	126,473		126,473		126,473			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		285,879	331,276	617,155		617,155		617,155			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,939,018	842,431	4,621,079	8,402,528		8,402,528	(179,720)	8,222,808			45

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,072	30		9
10	Interest and Other Investment Income	(5,813)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(744)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(550)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(350)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,000)	20		28
29	Other-Attach Schedule	(8,456)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (15,841)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 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)			34
35	Other- Attach Schedule	(163,879)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (163,879)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (179,720)		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 Yes	2 No	3 Amount	4 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

Chicago Ridge Nursing Center

ID# 0045815

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non Deductible Dues	$ (8,400)	20	1
2	Franchise Tax from Management Company	(37)	21	2
3	Sales Taxes from Management Company	(19)	2	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(8,456)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Chicago Ridge Nursing Center **#** 0045815 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	363,748	0	0	0	0	0	0	0	0	363,748	1
2	Food Purchase	(763)	0	155	0	0	0	0	0	0	0	0	(608)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	5,109	0	0	0	0	0	0	0	0	0	5,109	5
6	Maintenance	0	2,769	207,589	0	0	0	0	0	0	0	0	210,358	6
7	Other (specify):*	0	0	193	0	0	0	0	0	0	0	0	193	7
8	**TOTAL General Services**	(763)	7,878	571,685	0	0	0	0	0	0	0	0	578,800	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(795,733)	0	0	0	0	0	0	0	0	(795,733)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(350)	0	54,151	0	0	0	0	0	0	0	0	53,801	19
20	Fees, Subscriptions & Promotions	(9,400)	204	56	0	0	0	0	0	0	0	0	(9,140)	20
21	Clerical & General Office Expenses	(587)	3,558	141,026	5,558	0	0	0	0	0	0	0	149,555	21
22	Employee Benefits & Payroll Taxes	0	67,977	0	0	0	0	0	0	0	0	0	67,977	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	281	94	0	0	0	0	0	0	0	0	375	25
26	Insurance-Prop.Liab.Malpractice	0	597	211,570	0	0	0	0	0	0	0	0	212,167	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(10,337)	72,617	(388,836)	5,558	0	0	0	0	0	0	0	(320,998)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(11,100)	80,495	182,849	5,558	0	0	0	0	0	0	0	257,802	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Chicago Ridge Nursing Center **#** 0045815 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	1,072	0	944	434,430	0	0	0	0	0	0	0	436,446	30
31	Amortization of Pre-Op. & Org.	0	0	0	5,873	0	0	0	0	0	0	0	5,873	31
32	Interest	(5,813)	0	0	781,987	0	0	0	0	0	0	0	776,174	32
33	Real Estate Taxes	0	0	203,278	0	0	0	0	0	0	0	0	203,278	33
34	Rent-Facility & Grounds	0	0	0	(1,860,000)	0	0	0	0	0	0	0	(1,860,000)	34
35	Rent-Equipment & Vehicles	0	0	707	0	0	0	0	0	0	0	0	707	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(4,741)	0	204,929	(637,710)	0	0	0	0	0	0	0	(437,522)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(15,841)	80,495	387,778	(632,152)	0	0	0	0	0	0	0	(179,720)	45

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Marvin Mermelstein	30.20	RREM, Inc. d/b/a Winston Manor Nursing Home	Chicago	Nivram Mngmt, Inc.	Lincolnwood	Management
Joseph Mermelstein	5.20	Balmoral Home, Inc.	Chicago			
Barry Taerbaum	25.00					
Marvin Mermelstein Family Trust	19.8					
Joseph A. Mermelstein Family Trust	19.8					

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	25	Auto Expense	$	Nivram Management, Inc.	50.00%	$ 281	$ 281	1
2	V	21	Bank Charges		Nivram Management, Inc.	50.00%	7	7	2
3	V	21	Delivery Expense		Nivram Management, Inc.	50.00%	298	298	3
4	V	21	Contribution		Nivram Management, Inc.	50.00%	19	19	4
5	V	21	Office Expense		Nivram Management, Inc.	50.00%	3,049	3,049	5
6	V	20	Dues & Subscriptions		Nivram Management, Inc.	50.00%	204	204	6
7	V	21	Meals & Entertainment		Nivram Management, Inc.	50.00%	148	148	7
8	V	21	Franchise Tax		Nivram Management, Inc.	50.00%	37	37	8
9	V	22	Payroll Taxes		Nivram Management, Inc.	50.00%	45,474	45,474	9
10	V	5	Utilities		Nivram Management, Inc.	50.00%	5,109	5,109	10
11	V	26	Insurance		Nivram Management, Inc.	50.00%	597	597	11
12	V	6	Repairs & Maintenance		Nivram Management, Inc.	50.00%	2,769	2,769	12
13	V	22	Health Insurance		Nivram Management, Inc.	50.00%	22,503	22,503	13
14	Total			$			$ 80,495	$ * 80,495	14

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	Scavenger	$	Nivram Management, Inc.	50.00%	$ 193	$ 193	15
16	V	35	Rental Equipment		Nivram Management, Inc.	50.00%	707	707	16
17	V	2	Sales Taxes		Nivram Management, Inc.	50.00%	155	155	17
18	V	21	Postage		Nivram Management, Inc.	50.00%	529	529	18
19	V	19	Legal & Accounting		Nivram Management, Inc.	50.00%	1,001	1,001	19
20	V	20	Licenses & Permits		Nivram Management, Inc.	50.00%	56	56	20
21	V	25	Travel		Nivram Management, Inc.	50.00%	94	94	21
22	V	30	Depreciation		Nivram Management, Inc.	50.00%	944	944	22
23	V	21	Data Processing		Nivram Management, Inc.	50.00%	524	524	23
24	V	21	Telephone		Nivram Management, Inc.	50.00%	3,579	3,579	24
25	V	6	Plant Salary		Nivram Management, Inc.	50.00%	113,301	113,301	25
26	V	17	Assistant Administrator Salary		Nivram Management, Inc.	50.00%	169,952	169,952	26
27	V	21	Office Manager Salary		Nivram Management, Inc.	50.00%	38,187	38,187	27
28	V	1	Food Service Supervisor Salary		Nivram Management, Inc.	50.00%	363,748	363,748	28
29	V	17	Administrative Salaries		Nivram Management, Inc.	50.00%	91,731	91,731	29
30	V	17	Administrator Salary		Nivram Management, Inc.	50.00%	356,540	356,540	30
31	V	21	Clerical Salaries		Nivram Management, Inc.	50.00%	97,932	97,932	31
32	V	6	Maintenance Salary		Nivram Management, Inc.	50.00%	94,288	94,288	32
33	V	17	Management Fees	1,413,956	Nivram Management, Inc.	50.00%		(1,413,956)	33
34	V	21	Bank Service Charges		BM of Chicago Ridge Real Estate, LLC		25	25	34
35	V	19	Accounting Fees		BM of Chicago Ridge Real Estate, LLC		53,150	53,150	35
36	V	33	Real Estate Taxes		BM of Chicago Ridge Real Estate, LLC		203,278	203,278	36
37	V	26	Insurance Expense		BM of Chicago Ridge Real Estate, LLC		211,570	211,570	37
38	V	21	Other Taxes				250	250	38
39	Total			$ 1,413,956			$ 1,801,734	$ * 387,778	39

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	32	Mortgage Interest	$	BM of Chicago Ridge Real Estate, LLC		$ 794,852	$ 794,852	15
16	V	30	Depreciation Expense		BM of Chicago Ridge Real Estate, LLC		434,430	434,430	16
17	V	31	Amortization Expense		BM of Chicago Ridge Real Estate, LLC		5,873	5,873	17
18	V	21	Income Tax Expense		BM of Chicago Ridge Real Estate, LLC		5,558	5,558	18
19	V	34	Rental Income	1,860,000	BM of Chicago Ridge Real Estate, LLC			(1,860,000)	19
20	V	32	Interest Income	12,865	BM of Chicago Ridge Real Estate, LLC			(12,865)	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			$ 1,872,865			$ 1,240,713	$ * (632,152)	39

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Henry Mermelstein	Administrator	Administrative	0.00	123,333	13	33.33	Salary	$ 61,667	17-1	1
2	Louise Mermelstein	Dietary Supervisor	Support	0.00	727,497	7	33.34	Salary	363,748	1-7	2
3	Marvin Mermelstein	Plant Supervisor	Support	30.20	192,760	7	37.20	Salary	113,301	6-7	3
4	Dorren Mermelstein	Office Manager	Administrative	0.00	114,560	13	33.33	Salary	38,187	21-7	4
5											5
6	Marvin Mermelstein	Asst. Administrator	Administrative	See Above	289,139	10	37.20	Salary	169,952	17-7	6
7	Joseph Mermestein	Owner	Administrative	5.20	51,149	4	37.02	Salary	30,064	17-7	7
8	Barry Taerbaum	Administrator	Administrative	25.00	300,000	19	44.03	Salary	236,026	17-7	8
9	Marvin Mermelstein Family Trust		N/A	19.80				Salary	0		9
10	Joseph A. Mermelstein Family Trust		N/A	19.80				Salary	0		10
11											11
12											12
13								TOTAL	$ 1,012,945		13

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

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

Name of Related Organization: Nivram Management, Inc.
Street Address: 6500 N. Hamlin Avenue
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: (847) 679-7484
Fax Number: (847) 679-7494

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	25	Auto Expense	Resident Beds	624	3	$ 758	$	231	$ 281	1
2	21	Bank Charges	Resident Beds	624	3	19		231	7	2
3	21	Delivery Expense	Resident Beds	624	3	806		231	298	3
4	21	Contributions	Resident Beds	624	3	50		231	19	4
5	21	Office Expense	Resident Beds	624	3	8,235		231	3,049	5
6	20	Dues & Subscriptions	Resident Beds	624	3	552		231	204	6
7	21	Meals & Entertainment	Resident Beds	624	3	401		231	148	7
8	21	Franchise Tax	Resident Beds	624	3	100		231	37	8
9	22	Payroll Taxes	Resident Beds	624	3	122,839		231	45,474	9
10	5	Utilities	Resident Beds	624	3	13,801		231	5,109	10
11	26	Insurance	Resident Beds	624	3	1,613		231	597	11
12	6	Repairs & Maitenance	Resident Beds	624	3	7,479		231	2,769	12
13	22	Health Insurance	Resident Beds	624	3	60,786		231	22,503	13
14	7	Scavenger	Resident Beds	624	3	520		231	193	14
15	35	Rental Equipment	Resident Beds	624	3	1,911		231	707	15
16	2	Sales Taxes	Resident Beds	624	3	418		231	155	16
17	21	Postage	Resident Beds	624	3	1,430		231	529	17
18	19	Legal & Accounting	Resident Beds	624	3	2,703		231	1,001	18
19	20	Licenses & Permits	Resident Beds	624	3	150		231	56	19
20	25	Travel	Resident Beds	624	3	255		231	94	20
21	30	Derpeciation	Resident Beds	624	3	2,550		231	944	21
22	21	Data Processing	Resident Beds	624	3	1,416		231	524	22
23	21	Telephone	Resident Beds	624	3	9,669		231	3,579	23
24	6	Plant Salary	Direct Cost	1	1	113,301	113,301	1	113,301	24
25	TOTALS					$ 351,762	$ 113,301		$ 201,578	25

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

Name of Related Organization: Nivram Management, Inc.
Street Address: 6500 N. Hamlin Avenue
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: (847) 679-7484
Fax Number: (847) 679-7494

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Assistant Administrator	Direct Cost	1	1	$ 169,952	$ 169,952	1	$ 169,952	1
2	21	Office Manager Salary	Direct Cost	1	1	38,187	38,187	1	38,187	2
3	1	Food Sevice Supervisor Salary	Direct Cost	1	1	363,748	363,748	1	363,748	3
4	17	Administrative Salaries	Direct Cost	1	1	91,731	91,731	1	91,731	4
5	17	Administrator Salaries	Direct Cost	1	1	356,540	356,540	1	356,540	5
6	21	Clerical Salaries	Direct Cost	1	1	97,932	97,932	1	97,932	6
7	6	Maintenance Salary	Direct Cost	1	1	94,288	94,288	1	94,288	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					$ 1,212,378	$ 1,212,378		$ 1,212,378	25

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Deutsche Bank Mortgage, Inc.		X	Mortgage	$134,314.00	02/07/08	$ 13,345,000	$ 13,015,612	03/01/2043	6.0800	$ 794,852	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BM of Chicago Ridge R/E, LLC	X		Unpaid Rent		01/01/09	1,657,653		06/28/2010	3.2500	10,048	6
7												7
8												8
9	TOTAL Facility Related				$134,314.00		$ 15,002,653	$ 13,015,612			$ 804,900	9
	B. Non-Facility Related*											
10	Offset Against Int Income										(5,813)	10
11	Offset Against Int Income										(12,865)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (18,678)	14
15	TOTALS (line 9+line14)						$ 15,002,653	$ 13,015,612			$ 786,222	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 65,365 Line # 26

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

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

Facility Name & ID Number Chicago Ridge Nursing Center **#** 0045815 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	596,304	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	390,040	2
3. Under or (over) accrual (line 2 minus line 1).	$	(206,264)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	409,542	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND** $ _____ **For** _____ **Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	203,278	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	437,990	8
2006	467,569	9
2007	489,900	10
2008	574,384	11
2009	390,040	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.** This denial must be no more than four years old at the time the cost report is filed.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Chicago Ridge Nursing Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0045815

CONTACT PERSON REGARDING THIS REPORT Sanford B Alper

TELEPHONE (847) 580-4100 FAX #: (847) 580-4199

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	24-18-101-025-0000	Nursing Home	$ 283,320.18	$ 283,320.18
2.	24-18-101-039-0000	Nursing Home	$ 106,719.71	$ 106,719.71
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 390,039.89	$ 390,039.89

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 87,480 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3 + Basement

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	73,980	7/31/2007	$ 435,000	1
2					2
3	TOTALS	73,980		$ 435,000	3

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	231		2007		$ 9,936,943	$ 255,501	20-40	$ 255,500	$ (1)	$ 872,959	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sign			2001	1,419	36	39	36		332	9
10	Carpet			2002	2,240	58	39	58		491	10
11	Alarm			2002	22,000	564	39	564		4,630	11
12	Washer & Dryer			2002	29,304	752	39	752		6,669	12
13	Phone System			2002	10,667	273	39	273		2,199	13
14	A/C System			2002	11,200	287	39	287		2,309	14
15	Electrical Improvements			2002	3,000	77	39	77		619	15
16	Light Fixtures			2002	10,192	262	39	262		2,102	16
17	RC Alarm			2003	4,500	115	39	115		894	17
18	Water Heater			2003	16,500		5			16,500	18
19	Boiler			2004	21,500	552	39	552		3,308	19
20	Paving Improvements			2005	21,800	1,454	39	1,454		8,236	20
21	Bathroom Improvements			2005	634	16	39	16		88	21
22	Fire Smoke Dampers			2005	3,475	89	39	89		527	22
23	Boiler			2005	11,960	1,145	5	1,145		11,960	23
24	Locks			2006	4,374	112	39	112		458	24
25	Fire Alarm System			2006	98,711	2,531	39	2,531		10,335	25
26	AC Chiller Unit			2006	81,000	2,076	39	2,076		10,038	26
27	Furnance			2007	13,500	346	39	346		1,356	27
28	Temp Reset Control for Boiler			2007	2,750	70	39	70		270	28
29	Faucets			2007	2,298	59	39	59		226	29
30	Electrical Disconnect for Chiller Unit			2007	8,000	205	39	205		786	30
31	Add'l Amount for '06 AC Chiller Unit			2007	8,000	205	39	205		769	31
32	Hot Water Storage Tank			2007	22,000	564	39	564		2,021	32
33	Control System for New Chiller			2007	1,191	31	39	31		112	33
34	Grab Bars			2007	4,941	127	39	127		454	34
35	Boiler Room Change-Over Valves			2007	8,380	215	39	215		752	35
36	Water Coller, attached to Bld			2007	1,087	28	39	28		107	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Carpeting	2007	$ 3,138	$ 80	39	$ 80	$	$ 248	37
38	Alarm System	2009	7,784	200	39	200		500	38
39	Exhaust Fans	2009	7,098	182	39	182		273	39
40	Sprinkler System	2010	239,314	1,994	40	1,994		1,994	40
41	Boiler	2010	47,900	319	40	319		319	41
42	Electrical Breakers	2010	7,000	58	40	58		58	42
43	Fire Alarm	2010	8,982	150	40	150		150	43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 10,684,782	$ 270,733		$ 270,732	$ (1)	$ 965,049	70

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	$ 58,516	$ 7,165	$ 11,703	$ 4,538	5-7	$ 41,975	71
72	Current Year Purchases	10,163	793	793		5	793	72
73	Fully Depreciated Assets	46,336				5	46,336	73
74	Management & Real Estate Co	1,756,302	179,873	176,408	(3,465)	5-10	604,862	74
75	TOTALS	$ 1,871,317	$ 187,831	$ 188,904	$ 1,073		$ 693,966	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 12,991,099	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 458,564	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 459,636	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,072	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,659,015	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.

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: BM of Chicago Ridge Real Estate, L.L.C.
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. [X] 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 [X] NO Terms: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 3,424 Description: Copier - $2,717; Management Company - $707
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			204,803			204,803	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				246,348		246,348	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Attached Schedul						39,531		39,531	13
14	TOTAL			$		$ 204,803	$ 285,879		$ 490,682	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.

STATE OF ILLINOIS

Facility Name & ID Number Chicago Ridge Nursing Center **#** 0045815 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2010 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,413,542	$ 1,587,701	1
2	Cash-Patient Deposits	74,572	74,572	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	713,741	713,741	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,283	23,283	6
7	Other Prepaid Expenses	41,578	125,431	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Attached Schedule	14,105	788,293	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,280,821	$ 3,313,021	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		435,000	13
14	Buildings, at Historical Cost		9,936,943	14
15	Leasehold Improvements, at Historical Cost	379,098	682,294	15
16	Equipment, at Historical Cost	172,778	1,936,862	16
17	Accumulated Depreciation (book methods)	(175,924)	(1,654,134)	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 (spe Deposits	2,635	2,635	22
23	Other(specify): Deferred Loan Fees		196,426	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 378,587	$ 11,536,026	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,659,408	$ 14,849,047	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 491,126	$ 491,126	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	53,382	53,382	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	195,072	195,072	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		409,542	32
33	Accrued Interest Payable		65,945	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Attached Schedule	4,290,543	4,309,238	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,030,123	$ 5,524,305	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		13,015,612	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 13,015,612	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,030,123	$ 18,539,917	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,370,715)	$ (3,690,870)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,659,408	$ 14,849,047	48

***(See instructions.)**

Facility Name & ID Number Chicago Ridge Nursing Center **#** 0045815 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,004,865)	1
2	Restatements (describe):		2
3	Rounding	(6)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,004,871)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,184,156	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	(2,550,000)	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)**	$ (365,844)	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)**	$ (2,370,715)	24 *

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,476,431	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,476,431	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	44,974	6
7	Oxygen	35,414	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 80,388	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,813	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,813	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Attached Schedule	24,052	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 24,052	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,586,684	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,329,250	31
32	Health Care	2,562,163	32
33	General Administration	1,998,005	33
	B. Capital Expense		
34	Ownership	1,895,955	34
	C. Ancillary Expense		
35	Special Cost Centers	617,155	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,402,528	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,184,156	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,184,156	43

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

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

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

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

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,404	2,548	$ 83,404	$ 32.73	1
2	Assistant Director of Nursing					2
3	Registered Nurses	21,475	21,669	553,186	25.53	3
4	Licensed Practical Nurses	19,616	19,952	406,250	20.36	4
5	CNAs & Orderlies	73,554	76,705	761,598	9.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,097	2,097	29,314	13.98	9
10	Activity Assistants	7,366	7,723	66,778	8.65	10
11	Social Service Workers	12,186	12,400	237,433	19.15	11
12	Dietician					12
13	Food Service Supervisor	4,336	4,524	53,311	11.78	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,500	25,385	246,641	9.72	15
16	Dishwashers					16
17	Maintenance Workers	2,531	2,707	29,780	11.00	17
18	Housekeepers	26,746	28,497	256,172	8.99	18
19	Laundry	8,500	9,313	91,008	9.77	19
20	Administrator					20
21	Assistant Administrator	2,080	2,080	52,380	25.18	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,830	3,969	52,821	13.31	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,989	2,021	18,942	9.37	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	212,210	221,590	$ 2,939,018 *	$ 13.26	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 9,853	1-3	35
36	Medical Director	O			36
37	Medical Records Consultant	N	1,462	10-3	37
38	Nurse Consultant	T			38
39	Pharmacist Consultant	H			39
40	Physical Therapy Consultant	L			40
41	Occupational Therapy Consultant	Y			41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	F			43
44	Activity Consultant	E			44
45	Social Service Consultant	E	5,570	12-3	45
46	Other(specify)	S			46
47	Dental Consultant		400	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 17,285		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	10,876	$ 266,455	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	10,876	$ 266,455		53

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Darlene Guzy	Assistant Admin	0	$ 52,380
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 52,380

B. Administrative - Other

Description	Amount
Management Fees	$ 1,413,956
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,413,956
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
See Attached Schedule		55,190
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 55,190

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 52,665
Unemployment Compensation Insurance	32,419
FICA Taxes	241,474
Employee Health Insurance	30,653
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Allocation from Management Company	67,977
TOTAL (agree to Schedule V, line 22, col.8)	$ 425,188

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	995
Health Care Worker Background Check	
(Indicate # of checks performed 6)	60
Patient Background Checks 110	1,110
Yellow Pages Advertising	1,000
Attached Schedule	9,991
Allocation from Management Company	260
Accurate Biometrics - Fingerprinting	1,020
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(1,000)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,426

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,475
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,475

**See instructions.

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council Long Term Care $14,813**

(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? **5-10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **126,473**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees