FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0032011

Facility Name: Norridge Healthcare & Rehab Centre

Address: 7001 West Cullom (Number) Norridge (City) 60706 (Zip Code)

County: Cook

Telephone Number: (708) 457-0700 **Fax #** (708) 457-8852

HFS ID Number:

Date of Initial License for Current Owners: 1st Jan 1987

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Christopher Vicere **Telephone Number:** (773)604-4416
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 1-Jan-2010 to 31-Dec-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) March 31,2011
(Type or Print Name) Christopher Vicere
(Title) Vice President -Finance

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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 Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-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 None

	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	292	Skilled (SNF)	292	106,580	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	292	TOTALS	292	106,580	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	27,884	4,975	18,855	51,714	8
9	SNF/PED					9
10	ICF	39,377	6,921	638	46,936	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	67,261	11,896	19,493	98,650	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.56%

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 [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 1-Jan-1987

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 292 and days of care provided 17,463

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: 31-Dec-2010 Fiscal Year: 31-Dec-2010

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

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-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	747,596	128,607	22,938	899,141		899,141		899,141			1
2	Food Purchase		663,767		663,767	(33,339)	630,428	(798)	629,630			2
3	Housekeeping	463,670	127,195		590,865		590,865		590,865			3
4	Laundry	219,327	47,913		267,240		267,240		267,240			4
5	Heat and Other Utilities			310,908	310,908		310,908		310,908			5
6	Maintenance	130,098	134,370	213,187	477,655		477,655	(1,498)	476,157			6
7	Other (specify):*											7
8	TOTAL General Services	1,560,691	1,101,852	547,033	3,209,576	(33,339)	3,176,237	(2,296)	3,173,941			8
	B. Health Care and Programs											
9	Medical Director			34,500	34,500		34,500		34,500			9
10	Nursing and Medical Records	6,598,164	749,521	45,371	7,393,056		7,393,056		7,393,056			10
10a	Therapy		9,162	112,440	121,602		121,602		121,602			10a
11	Activities	203,677	41,291		244,968		244,968		244,968			11
12	Social Services	183,308		6,005	189,313		189,313		189,313			12
13	CNA Training		1,508	2,571	4,079		4,079		4,079			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	6,985,149	801,482	200,887	7,987,518		7,987,518		7,987,518			16
	C. General Administration											
17	Administrative	177,185		525,600	702,785		702,785	(173,388)	529,397			17
18	Directors Fees											18
19	Professional Services			105,168	105,168		105,168	21,730	126,898			19
20	Dues, Fees, Subscriptions & Promotions			52,034	52,034		52,034	(28,825)	23,209			20
21	Clerical & General Office Expenses	389,918	103,422	298,879	792,219		792,219	(37,169)	755,050			21
22	Employee Benefits & Payroll Taxes			1,485,664	1,485,664	33,339	1,519,003	12,692	1,531,695			22
23	Inservice Training & Education			112	112		112		112			23
24	Travel and Seminar			8,836	8,836		8,836	735	9,571			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			36,055	36,055		36,055		36,055			26
27	Other (specify):* Payroll Taxes (Schedule VII)							48,191	48,191			27
28	TOTAL General Administration	567,103	103,422	2,512,348	3,182,873	33,339	3,216,212	(156,034)	3,060,178			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	9,112,943	2,006,756	3,260,268	14,379,967		14,379,967	(158,330)	14,221,637			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 Norridge Healthcare & Rehab Centre #0032011 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-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			305,501	305,501		305,501	242,716	548,217			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							1,512,525	1,512,525			32
33	Real Estate Taxes			870,478	870,478		870,478		870,478			33
34	Rent-Facility & Grounds			2,489,931	2,489,931		2,489,931	(2,484,000)	5,931			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			3,665,910	3,665,910		3,665,910	(728,759)	2,937,151			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		759,153	1,622,127	2,381,280		2,381,280		2,381,280			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			159,870	159,870		159,870		159,870			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		759,153	1,781,997	2,541,150		2,541,150		2,541,150			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	9,112,943	2,765,909	8,708,175	20,587,027		20,587,027	(887,089)	19,699,938			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 Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-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	35,741	30		9
10	Interest and Other Investment Income	(12,125)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(798)	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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(237,536)	21		24
25	Fund Raising, Advertising and Promotional	(135,990)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(14,695)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(300)	20		28
29	Other-Attach Schedule Per page 5A	(3,792)	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (369,495)		$	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)	(517,594)	Pgs 6&6A	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (517,594)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (887,089)		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

Norridge Healthcare & Rehab Centre

ID# 0032011

Report Period Beginning: 1-Jan-2010

Ending: 31-Dec-2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Painting & Decorating incurred in 2010	$ (6,033)	6	1
2	Painting & Decorating allocated for 2010	2,241	6	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(3,792)		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Norridge Healthcare & Rehab Centre **#** 0032011 **Report Period Beginning:** 1-Jan-2010 **Ending:** 31-Dec-2010

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(798)	0	0	0	0	0	0	0	0	0	0	(798)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(3,792)	2,294	0	0	0	0	0	0	0	0	0	(1,498)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,590)	2,294	0	0	0	0	0	0	0	0	0	(2,296)	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	(173,388)	0	0	0	0	0	0	0	0	0	(173,388)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	19,680	2,050	0	0	0	0	0	0	0	0	21,730	19
20	Fees, Subscriptions & Promotions	(136,290)	107,465	0	0	0	0	0	0	0	0	0	(28,825)	20
21	Clerical & General Office Expenses	(252,231)	210,167	4,895	0	0	0	0	0	0	0	0	(37,169)	21
22	Employee Benefits & Payroll Taxes	0	12,692	0	0	0	0	0	0	0	0	0	12,692	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	735	0	0	0	0	0	0	0	0	0	735	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	48,191	0	0	0	0	0	0	0	0	0	48,191	27
28	**TOTAL General Administration**	(388,521)	225,542	6,945	0	0	0	0	0	0	0	0	(156,034)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(393,111)	227,836	6,945	0	0	0	0	0	0	0	0	(158,330)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 **Report Period Beginning:** 1-Jan-2010 **Ending:** 31-Dec-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	35,741	7,393	199,582	0	0	0	0	0	0	0	0	242,716	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12,125)	33,812	1,490,838	0	0	0	0	0	0	0	0	1,512,525	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(2,484,000)	0	0	0	0	0	0	0	0	(2,484,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	23,616	41,205	(793,580)	0	0	0	0	0	0	0	0	(728,759)	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)	(369,495)	269,041	(786,635)	0	0	0	0	0	0	0	0	(887,089)	45

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-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

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	17	Management Fee Income	$ 525,600	Lancaster, Ltd.	100.00%	$	$ (525,600)	1
2	V	17	Officers' Salaries		Lancaster, Ltd.	100.00%	95,716	95,716	2
3	V	27	Payroll Taxes-Officers & Staff		Lancaster, Ltd.	100.00%	48,191	48,191	3
4	V	19	Professional Services		Lancaster, Ltd.	100.00%	19,680	19,680	4
5	V	21	Clerical Expenses		Lancaster, Ltd.	100.00%	210,167	210,167	5
6	V	22	Employee Benefits		Lancaster, Ltd.	100.00%	12,692	12,692	6
7	V	24	Seminars and Travel		Lancaster, Ltd.	100.00%	735	735	7
8	V	17	Administrative Consulting		Lancaster, Ltd.	100.00%	256,496	256,496	8
9	V	20	Dues,Subscriptions & Marketing Fees		Lancaster, Ltd.	100.00%	107,465	107,465	9
10	V	30	Depreciation		Lancaster, Ltd.	100.00%	7,393	7,393	10
11	V	6	Repairs and Maintenance		Lancaster, Ltd.	100.00%	2,294	2,294	11
12	V	32	Interest		Lancaster, Ltd.	100.00%	13,360	13,360	12
13	V	32	**Direct Interest**		Lancaster, Ltd.	100.00%	20,452	20,452	13
14	Total			$ 525,600			$ 794,641	$ * 269,041	14

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

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-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	34	Rental Income	$ 2,484,000	Norridge Associates		$	$ (2,484,000)	15
16	V	32	Interest	9,162	Norridge Associates		1,500,000	1,490,838	16
17	V	30	Depreciation		Norridge Associates		199,582	199,582	17
18	V	19	Accounting Fees		Norridge Associates		2,050	2,050	18
19	V	21	State Replacement Tax		Norridge Associates		4,895	4,895	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			$ 2,493,162			$ 1,706,527	$ * (786,635)	39

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

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-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	Christopher Vicere	VP-Finance	Administrative		See Attached	13.5	28.13	Lancaster	$ 47,858	17-7	1
2	Cheryl Morris	VP-Operations	Administrative		See Attached	13.5	28.13	Lancaster	47,858	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 95,716		13

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

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

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-2010 Ending: -Dec-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: Lancaster, Ltd.
Street Address: 5061 N. Pulaski Road
City / State / Zip Code: Chicago, IL 60630
Phone Number: (773)604-4416
Fax Number: (773)478-1192

	1 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	Christopher Vicere	Hours Worked	48	4	$ 170,160	$ 170,160	14	$ 47,858	1
2	27	Christopher Vicere-payroll tax	Hours Worked	48	4	9,439		14	2,655	2
3	17	Cheryl Morris	Hours Worked	48	4	170,160	170,160	14	47,858	3
4	27	Cheryl Morris-payroll tax	Hours Worked	48	4	9,420		14	2,649	4
5										5
6										6
7	19	Professional Services	Census Days	311,995	4	62,241		98,650	19,680	7
8	21	Clerical Expenses	Census Days	311,995	4	664,683	623,280	98,650	210,167	8
9	22	Employee Benefits	Census Days	311,995	4	40,140		98,650	12,692	9
10	24	Seminars and Travel	Census Days	311,995	4	2,324		98,650	735	10
11	17	Administrative Consulting	Census Days	311,995	4	811,207	811,207	98,650	256,496	11
12	20	Marketing Fees	Census Days	311,995	4	332,596	327,507	98,650	105,164	12
13	20	Dues, Fees and Subscriptions	Census Days	311,995	4	7,277		98,650	2,301	13
14	30	Depreciation	Census Days	311,995	4	23,380		98,650	7,393	14
15	6	Repairs and Maintenance	Census Days	311,995	4	7,255		98,650	2,294	15
16	27	Payroll Taxes	Census Days	311,995	4	135,636		98,650	42,887	16
17	32	Interest	Census Days	311,995	4	42,252		98,650	13,360	17
18										18
19										19
20	32	**Direct Interest**							20,452	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,488,169	$ 2,102,314		$ 794,641	25

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Harston Investments		X	Working Capital							1,500,000	6
7	JP Morgan Chase Bank Plc.		X	Working Capital							13,360	7
8												8
9	TOTAL Facility Related						$	$			$ 1,513,360	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 1,513,360	15

Set-Off Interest Income (835)

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # N/A 1,512,525

Pg 4 Line 32 Col 8

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

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

Facility Name & ID Number Norridge Healthcare & Rehab Centre **#** 0032011 **Report Period Beginning:** 1-Jan-2010 **Ending:** 31-Dec-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.**	$ 580,000	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.)		$ 704,478	2
3. Under or (over) accrual (line 2 minus line 1).		$ 124,478	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 746,000	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.		$ 870,478	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	509,988	8
	2006	506,138	9
	2007	535,993	10
	2008	564,066	11
	2009	704,478	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 Norridge Healthcare & Rehab Centre COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0032011

CONTACT PERSON REGARDING THIS REPORT Christopher Vicere

TELEPHONE 773-604-4416 FAX #: 773-478-1192

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.	13-18-318-005-0000	Long-Term Healthcare	$ 175,854.33	$ 175,854.33
2.	13-18-318-006-000	Long-Term Healthcare	$ 175,854.33	$ 175,854.33
3.	13-18-318-007-0000	Long-Term Healthcare	$ 176,915.45	$ 176,915.45
4.	13-18-318-008-0000	Long-Term Healthcare	$ 175,854.33	$ 175,854.33
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 704,478.44	$ 704,478.44

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 Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [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. [ ] (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 [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 Facility		1986	$ 650,000	1
2	Sect754 basis adj			126,788	2
3	TOTALS			$ 776,788	3

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-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	292		1986	1976	$ 9,204,000	$	30	$	$	$ 9,204,000	4
5					1,315,965	41,777	30	41,777		797,004	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	43,548	1,382	20		(1,382)	43,548	9
10	Various			1988	3,939	125	20		(125)	3,939	10
11	Various			1988	28,574	459	20		(459)	28,574	11
12	Various			1989	1,297	41	20		(41)	1,297	12
13	Various			1990	3,827	121	20	48	(73)	3,827	13
14	Various			1990	28,644	909	20	857	(52)	28,644	14
15	Various			1991	72,916	2,314	20	3,650	1,336	70,559	15
16	Various			1992	36,639	950	20	1,497	547	34,478	16
17	Various			1993	72,513	1,920	20	3,627	1,707	63,914	17
18	Various			1994	116,353	2,936	20	5,728	2,792	95,846	18
19	Various			1995	95,409	2,447	20	4,770	2,323	76,033	19
20	Boiler/Hot Water Heater Improvements			1996	9,417	241	20	471	230	7,063	20
21	Tuckpointing			1999	28,900	741	20	1,445	704	16,738	21
22	Architect Fee 1st Floor			2001	15,052	386	39	386		3,812	22
23	Construction 1st Floor			2001	166,662	4,273	39	4,273		42,197	23
24	Constrution Library			2001	12,461	320	39	320		3,159	24
25	Design Fee-1st Floor			2001	5,130	132	39	132		1,303	25
26	Sprinklers-1st Floor			2001	4,531	116	39	116		1,146	26
27	Demolition-1st Floor			2001	5,533	142	39	142		1,402	27
28	Wooden Doors (2)			2001	1,134	29	39	29		287	28
29	Construction Work			2002	4,207	108	39	108		1,003	29
30	Smoking Shelter			2002	3,251	83	10	325	242	2,925	30
31	Auto Front Door			2002	2,074	53	10	207	154	1,777	31
32	Fence In Lot			2003	2,972	88	15	198	110	1,436	32
33	Building New-Town Square			2003	281,539	16,610	15	19,508	2,898	139,807	33
34	Roofing			2003	62,440	1,601	39	6,244	4,643	44,749	34
35	Wanderguard			2004	964		10	96	96	656	35
36	Refuse Inclosure			2004	2,395		10	240		1,520	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-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	Fire alarm System	2004	$ 104,400	$	5	$ 14,914	$ 14,914	$ 100,670	37
38	Patio Concrete	2004	2,500	64	39	250	186	1,729	38
39	Air Ventilation System	2004	26,794	687	39	2,233	1,546	14,700	39
40	Design & Development of Town Square	2004	42,130	1,080	39	4,213	3,133	28,789	40
41	Consultancy Fire Alarm Installation	2004	22,700		5	3,243	3,243	21,890	41
42	Hand Rail System	2005	6,025	154	10	603	449	3,517	42
43	Duct Detectors	2005	2,061	53	5	69	16	2,061	43
44	20 Ton Roof Top Aircon	2005	17,635	452	5	1,470	1,018	17,635	44
45	Elevator Fire Upgrade	2005	46,440	1,191	5	3,870	2,679	46,440	45
46	Concrete Approach Pad	2005	2,160	55	10	216	161	1,170	46
47	27 Plastic Laminate Doors	2006	6,145	158	10	615	457	2,972	47
48	10T Rooftop A/C W/Exhaust	2006	24,668	632	10	2,467	1,835	11,307	48
49	Wanderguard	2006	1,000	26	10	100	74	417	49
50	Laminate 2x Egress Doors	2007	4,361	112	10	436	324	1,599	50
51	Electrical Fittings, Fixtures & Holders 2nd Floor	2007	6,512	167	39	651	484	2,116	51
52	Construction Cost-2nd Floor & Dementia Unit	2007	294,274	7,546	39	29,427	21,881	95,638	52
53	Architechtural Cost-2nd Floor & Dementia Unit	2007	13,657	350	39	1,366	1,016	4,439	53
54	Wallcoverings,Borders,Accent Tiles,Murals-2nd FL	2007	41,777	1,071	39	4,178	3,107	13,579	54
55	Fixtures & Fittings Incl.countertops,Sinks&Blinds	2007	56,845	1,457	39	5,684	4,227	18,473	55
56	Glazed/Unglazed Vinyl/Ceramic Tiles&Floor Coverings	2007	34,919	895	39	3,492	2,597	11,349	56
57	Cabinetry For 2nd Floor & Dementia Unit	2007	96,950	13,263	5	19,390	6,127	63,018	57
58	Bed Annunciator Panel	2009	12,900	2,064	5	2,580	516	4,085	58
59	Islandaire Unit	2009	14,722	377	10	1,472	1,095	2,331	59
60	Replacement of Boilers	2009	97,850	2,509	10	9,785	7,276	12,231	60
61	New Gas Pipe Laid	2009	3,247	83	10	325	242	406	61
62	New Door	2009	1,552	40	10	155	115	181	62
63	30 x Signalling Boxes	2009	1,023	164	5	205	41	222	63
64	Architechtural & CAD Services, Permit/License Fee-4th Floor	2009	7,010	180	39	701	521	1,052	64
65	Remove & Rebuild walls,Tiles,Plumbing,Lights-4th Floor	2009	157,001	4,026	39	15,700	11,674	23,551	65
66	Cabinet,Counter,Wall/Window treatment-Activity Rm-4th Flr	2009	14,122	10,567	5	1,412	(9,155)	2,118	66
67	Shower Room w/lights,tiles,mirror,vanity,Heat lamps-4th Flr	2009	7,109	182	39	711	529	1,066	67
68	Built-in wooden File cabinet with doors-Nursing Area-4th Flr	2009	13,250	9,914	5	1,325	(8,589)	1,988	68
69	Built-in Display Unit w/molding & Pilasters-Music Area-4th Flr	2009	6,120	4,579	5	612	(3,967)	918	69
70	TOTAL (lines 4 thru 69)		$ 12,822,145	$ 144,402		$ 230,064	$ 85,422	$ 11,236,300	70

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

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-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	
1	Totals from Page 12A, Carried Forward		$ 12,822,145	$ 144,402		$ 230,064	$ 85,662	$ 11,236,300	1
2	Acoustical Ceiling Tiles on 4th Floor	2009	24,998	641	39	2,500	1,859	3,750	2
3	Light Fixtures for Central Area on 4th Floor	2009	14,447	370	39	1,445	1,075	2,167	3
4	Corner Guards, rails, Carpets,Cabinets-Central Area-4th Flr	2009	36,047	26,972	5	3,605	(23,367)	5,407	4
5	Tiles, Counter Tops, Corner Guards,Sink, cabinets-4th Floor	2009	21,854	3,497	5	4,371	874	6,556	5
6	Wall Protection Material & Adhesive - 4th Floor	2009	21,860	3,498	5	4,372	874	6,558	6
7	Architectural/Structural Srvcs,Alarm & Permit fees-PT Room	2010	43,732	983	39	4,009	3,026	4,009	7
8	Construction,Fire Alarm,Ceiling,Plumbing-New PT Room	2010	455,459	10,234	39	41,750	31,516	41,750	8
9	Steel Stairs & Hand rails Installed in New PT Room	2010	7,245	163	39	664	501	664	9
10	RPZ, Sprinkler & Fire Alarm System Installed in PT Room	2010	31,766	714	39	2,912	2,198	2,912	10
11	Glass Installed on Walls of PT Room	2010	30,180	678	39	2,767	2,089	2,767	11
12	Heating/Cooling Installation & Exterior Insulation-PT Room	2010	74,470	1,673	39	6,826	5,153	6,826	12
13	Floor Tiles,Painting,Mural,Molding,Ceiling Lights-PT Room	2010	72,811	1,636	39	6,674	5,038	6,674	13
14	Electrical Lines to Laundry Section	2010	23,166	13,900	5	3,475	(10,425)	3,475	14
15	Physical Therapy Room Wall cabinets	2010	5,700	3,420	5	665	(2,755)	665	15
16	Counter Fire Steel Reinforced Doors	2010	8,140	96	10	407	311	407	16
17	Laundry Room Air Conditioning System	2010	10,900	6,540	5	908	(5,632)	908	17
18	Kitchen Refrigeration System	2010	13,560	8,136	5	904	(7,232)	904	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)		$ 13,718,480	$ 227,553		$ 318,318	$ 90,765	$ 11,332,699	34

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

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-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	$ 790,771	$ 81,521	$ 147,425	$ 65,904	7	$ 439,874	71
72	Current Year Purchases	297,911	192,580	64,399	(128,181)	7	64,399	72
73	Fully Depreciated Assets	2,059,921	3,429	10,682	7,253	7	2,059,921	73
74	*Lancaster Allocation*		7,393	7,393			41,146	74
75	TOTALS	$ 3,148,603	$ 284,923	$ 229,899	$ (55,024)		$ 2,605,340	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)	$ 17,643,871	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 512,476	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 548,217	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 35,741	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 13,938,039	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 Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: ***Lease held by Norridge Property Associates-a Related Party***

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [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		***Off-site Public Storage***			5,931			5
6								6
7	TOTAL				$ 5,931 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

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

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

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

C. Vehicle Rental (See instructions.)

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

* 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 Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-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? [X] YES [ ] 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	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER CNA	96

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER CNA	48

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies	295	1,213		1,508
3	Classroom Wages (a)	503	2,068		2,571
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$ 798	$ 3,281	$	$ 4,079
10	SUM OF line 9, col. 1 and 2 (e)	$ 4,079			

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	36
2. From other facilities (f)	1
DROP-OUTS	
1. From this facility	9
2. From other facilities (f)	
TOTAL TRAINED	46

(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 Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-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	39-3	hrs	$		$ 706,526	$		$ 706,526	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			169,369			169,369	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			737,011			737,011	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation **Inhalation Therapy*	39-3	hrs			9,221			9,221	8
9	Pharmacy	39-2	# of prescrpts				640,672		640,672	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): **Medical Supplies**	39-2					66,857		66,857	12
13	Other (specify): **Bed Rental**	39-2					51,624		51,624	13
14	TOTAL			$		$ 1,622,127	$ 759,153		$ 2,381,280	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 Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 31-Dec-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	$ 24,909	$ 24,909	1
2	Cash-Patient Deposits	98,718	98,718	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,627,943	2,627,943	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	65,963	65,963	6
7	Other Prepaid Expenses	6,153	6,153	7
8	Accounts Receivable (owners or related parties)	3,115,332	4,860,078	8
9	Other(specify): **Refundable Deposits**	6,200	6,200	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,945,218	$ 7,689,964	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		776,788	13
14	Buildings, at Historical Cost		10,519,965	14
15	Leasehold Improvements, at Historical Cost	1,071,598	3,198,516	15
16	Equipment, at Historical Cost	2,519,092	3,148,606	16
17	Accumulated Depreciation (book methods)	(2,734,695)	(13,853,893)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		165,278	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(165,278)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **Goodwill**	100,000	100,000	22
23	Other(specify): **Consruction-in-Progress**		435,904	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 955,995	$ 4,325,886	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,901,213	$ 12,015,850	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 391,308	$ 391,308	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	115,817	115,817	28
29	Short-Term Notes Payable	437,883	437,883	29
30	Accrued Salaries Payable	699,160	699,160	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,435	16,435	31
32	Accrued Real Estate Taxes(Sch.IX-B)	746,000	746,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,406,603	$ 2,406,603	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		15,000,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 15,000,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,406,603	$ 17,406,603	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,494,610	$ (5,390,753)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,901,213	$ 12,015,850	48

*(See instructions.)

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,515,110	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,515,110	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,366,747	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	(2,000,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) ***Treasury Stock***	(387,247)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,020,500)	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)**	$ 4,494,610	24 *

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

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

XVI. STATEMENT OF CHANGES IN EQUITY

		Total after consolidation	
1	**Balance at Beginning of Year, as Previously Reported**	$ (5,156,888)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (5,156,888)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,153,382	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	(2,000,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) ***Treasury Stock***	(387,247)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (233,865)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (5,390,753)	24 *

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

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-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	$ 23,316,747	1
2	Discounts and Allowances for all Levels	(6,339,599)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 16,977,148	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,805,157	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,805,157	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	122,821	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	706,147	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,703	19
20	Radiology and X-Ray	75,220	20
21	Other Medical Services	233,953	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,153,844	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12,125	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12,125	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Commissions	5,500	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,500	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 21,953,774	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	3,209,576	31
32	Health Care	7,987,518	32
33	General Administration	3,182,873	33
	B. Capital Expense		
34	Ownership	3,665,910	34
	C. Ancillary Expense		
35	Special Cost Centers	2,381,280	35
36	Provider Participation Fee	159,870	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 20,587,027	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,366,747	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,366,747	43

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

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

******* **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. **Offset pg 5 & 9****

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

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-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	1,563	1,617	$ 66,732	$ 41.27	1
2	Assistant Director of Nursing	6,311	7,107	266,402	37.48	2
3	Registered Nurses	94,279	100,182	2,804,218	27.99	3
4	Licensed Practical Nurses	24,374	25,485	646,841	25.38	4
5	CNAs & Orderlies	224,964	242,880	2,713,860	11.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,962	2,209	51,292	23.22	9
10	Activity Assistants	12,012	13,197	152,385	11.55	10
11	Social Service Workers	10,944	12,214	183,308	15.01	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	54,933	61,070	747,596	12.24	15
16	Dishwashers					16
17	Maintenance Workers	6,133	6,765	130,098	19.23	17
18	Housekeepers	36,992	41,202	463,670	11.25	18
19	Laundry	20,059	22,110	219,327	9.92	19
20	Administrator	1,885	2,086	120,795	57.91	20
21	Assistant Administrator	2,021	2,086	56,390	27.03	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	21,235	23,523	389,918	16.58	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	7,975	8,773	100,111	11.41	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	527,642	572,506	$ 9,112,943 *	$ 15.92	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	695	$ 22,938	1-3	35
36	Medical Director	900	34,500	9-3	36
37	Medical Records Consultant	163	4,416	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	1,190	38,995	10-3	39
40	Physical Therapy Consultant	3,335	111,740	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	200	6,005	12-3	45
46	Other(specify)				46
47	Dementia Consultant	20	700	10a-3	47
48					48
49	TOTAL (lines 35 - 48)	6,503	$ 219,294		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	65	$ 1,960	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	65	$ 1,960		53

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Safet Keljalic	Administrator		$ 120,795
Jina Lebert-Davies	Asst. Administrator		56,390
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 177,185

B. Administrative - Other

Description	Amount
Management Fees-Lancaster, Ltd	$ 525,600
TOTAL (agree to Schedule V, line 17, col. 3)	$ 525,600
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	Payroll Tax Consultant	$ 2,468
Frost,Ruttenberg & Rothblatt	Accounting	1,750
Richard Peelo & Assoc., Inc	Accounting	2,250
Myers, Miller & Krauskopf	Legal	1,776
Law Office of Carter A. Korey	Legal	27,377
Klein Law Offices	Legal	7,540
Kenneth A Henry	Legal	3,605
Polsinelli Shughart P.C.	Legal	978
Law Office of Kathleen	Legal	1,010
Law Office of Alice D Borzym	Legal	700
Expenses brought forward	Data Processing	55,714
(Refer details on Pg 21 A attached)		
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 105,168

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 112,251
Unemployment Compensation Insurance	70,620
FICA Taxes	671,719
Employee Health Insurance	471,037
Employee Meals	33,339
Illinois Municipal Retirement Fund (IMRF)*	
Employment Fees	52,513
Misc. Employment Benefits	17,143
Uniforms	3,720
Retiremnt Plan Contribution	86,661
Lancster Allocation	12,692
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,531,695

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	7,487
Health Care Worker Background Check	3,150
(Indicate # of checks performed 315)	
Patient Background Checks 339	3,390
Promotional Advertising	28,825
Contributions	950
Dues & Subscriptions	1,775
Licenses & Fees	4,467
Related Parties Allocation	107,465
Less: Public Relations Expense	(28,525)
Non-allowable advertising	(107,465)
Yellow page advertising	(300)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,209

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,808
Seminar Expense	5,028
Lancaster Allocation	735
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,571

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-2010

XIX. SUPPORT SCHEDULES Continued

Continuation Sheet attached to and forming part of Page 21, Schedule XIX, Item C

C. Professional Services

Vendor/Payee	Type	Amount
HealthData Systems, Inc.	Data Processing	$ 8,242
Medifax-EDI	Data Processing	1,968
Accu-Med Services Inc.	Data Processing	3,780
E-Health Solutions, Inc.	Data Processing	39,997
Long Term Care	Data Processing	990
Towerstream Corporation	Data Processing	516
Sprint, Plc	Data Processing	221
TOTAL		
Data Processing expenses carried over to Page 21 Item C.		$ 55,714

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1-Jan-2010 Ending: 31-Dec-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	Painting & Decorating	July-2007	$ 320	3	$ 27	$ 53	$ 53	$ 27	$	$	$	$	$
2	Painting & Decorating	2008	900	3	27	75	150	150	75				
3	Painting & Decorating	2009	1,535	3			256	511	511	256			
4	Painting & Decorating	Feb-2010	3,288	3				1,096	1,096	1,096			
5	Painting & Decorating	Oct-2010	2,745	3				457	915	915	458		
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 8,788		$ 54	$ 128	$ 459	$ 2,241	$ 2,597	$ 2,267	$ 458	$	$

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 **Report Period Beginning:** 1-Jan-2010 **Ending:** 31-Dec-201(

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **117,232** Line **10-2**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **159,870**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **33,339** Has any meal income been offset against related costs? **None** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **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.