FOR BHF USE

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 32011

Facility Name: NORRIDGE HLTHCR & REHAB CENTRE

Address: 7001 W. Cullom Ave. (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-2011 to 31-Dec-2011 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) 29th March, 2012 (Date)
(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 HLTHCR & REHAB CENTRE # 32011 Report Period Beginning: 1-Jan-2011 Ending: 31-Dec-2011

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	22,596	4,159	20,729	47,484	8
9	SNF/PED					9
10	ICF	44,003	8,612	38	52,653	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	66,599	12,771	20,767	100,137	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.95%

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 20,241

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: 31st Dec 2011 Fiscal Year: 31st Dec 2011

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

Facility Name & ID Number NORRIDGE HLTHCR & REHAB CENTRE # 32011 Report Period Beginning: 1-Jan-2011 Ending: 31-Dec-2011

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	789,148	148,144	23,275	960,567		960,567		960,567			1
2	Food Purchase		726,276		726,276	(35,937)	690,339	(923)	689,416			2
3	Housekeeping	491,749	132,580		624,329		624,329		624,329			3
4	Laundry	214,886	77,044		291,930		291,930		291,930			4
5	Heat and Other Utilities			270,026	270,026		270,026		270,026			5
6	Maintenance	131,420	234,386	204,481	570,287		570,287	(372)	569,915			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,627,203	1,318,430	497,782	3,443,415	(35,937)	3,407,478	(1,295)	3,406,183			8
	B. Health Care and Programs											
9	Medical Director			35,000	35,000		35,000		35,000			9
10	Nursing and Medical Records	6,774,258	745,408	27,761	7,547,427		7,547,427		7,547,427			10
10a	Therapy		20,732	86,816	107,548		107,548		107,548			10a
11	Activities	260,416	51,232	11,371	323,019		323,019		323,019			11
12	Social Services	182,283		6,285	188,568		188,568		188,568			12
13	CNA Training		601	2,340	2,941		2,941		2,941			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	7,216,957	817,973	169,573	8,204,503		8,204,503		8,204,503			16
	C. General Administration											
17	Administrative	180,216		525,600	705,816		705,816	(116,704)	589,112			17
18	Directors Fees											18
19	Professional Services			113,999	113,999		113,999	27,163	141,162			19
20	Dues, Fees, Subscriptions & Promotions			51,493	51,493		51,493	(31,424)	20,069			20
21	Clerical & General Office Expenses	427,505	163,461	207,287	798,253		798,253	149,544	947,797			21
22	Employee Benefits & Payroll Taxes			1,584,887	1,584,887	35,937	1,620,824	13,576	1,634,400			22
23	Inservice Training & Education			26	26		26	41,596	41,622			23
24	Travel and Seminar			16,355	16,355		16,355	2,491	18,846			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			266,921	266,921		266,921		266,921			26
27	Other (specify):* *Payroll Taxes (Sch VII)							54,930	54,930			27
28	**TOTAL General Administration**	607,721	163,461	2,766,568	3,537,750	35,937	3,573,687	141,172	3,714,859			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	9,451,881	2,299,864	3,433,923	15,185,668		15,185,668	139,877	15,325,545			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 HLTHCR & REHAB CENTRE #32011 Report Period Beginning: 1-Jan-2011 Ending: 31-Dec-2011

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			208,108	208,108		208,108	392,728	600,836			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							1,465,095	1,465,095			32
33	Real Estate Taxes			736,568	736,568		736,568		736,568			33
34	Rent-Facility & Grounds			2,492,277	2,492,277		2,492,277	(2,484,000)	8,277			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			3,436,953	3,436,953		3,436,953	(626,177)	2,810,776			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		903,884	1,873,301	2,777,185		2,777,185		2,777,185			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):* *Addl.State Fee @$6.07**			332,606	332,606		332,606		332,606			43
44	TOTAL Special Cost Centers		903,884	2,365,777	3,269,661		3,269,661		3,269,661			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	9,451,881	3,203,748	9,236,653	21,892,282		21,892,282	(486,300)	21,405,982			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 HLTHCR & REHAB CENTRE # 32011 Report Period Beginning: 1-Jan-2011 Ending: 31-Dec-2011

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	(39,933)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(923)	2		13
14	Non-Care Related Interest	(58,961)	32		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	(850)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(82,186)	21		24
25	Fund Raising, Advertising and Promotional	(173,112)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,415)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Page 5A attached	(979)	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (361,359)		$	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)	(124,941)	6,6A &6B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (124,941)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (486,300)		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

STATE OF ILLINOIS

NORRIDGE HLTHCR & REHAB CENTRE

ID# 32011

Report Period Beginning: 1-Jan-2011

Ending: 31-Dec-2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Painting & Decorating incurred in 2011	$ (4,745)	6	1
2	Painting & Decorating allocated for 2011	3,766	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**	(979)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number NORRIDGE HLTHCR & REHAB CENTRE # 32011 **Report Period Beginning:** 1-Jan-2011 **Ending:** 31-Dec-2011

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	(923)	0	0	0	0	0	0	0	0	0	0	(923)	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	(979)	607	0	0	0	0	0	0	0	0	0	(372)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,902)	607	0	0	0	0	0	0	0	0	0	(1,295)	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	232,584	(349,288)	0	0	0	0	0	0	0	0	(116,704)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	24,913	0	2,250	0	0	0	0	0	0	0	27,163	19
20	Fees, Subscriptions & Promotions	(173,962)	142,538	0	0	0	0	0	0	0	0	0	(31,424)	20
21	Clerical & General Office Expenses	(86,601)	231,730	0	4,415	0	0	0	0	0	0	0	149,544	21
22	Employee Benefits & Payroll Taxes	0	13,576	0	0	0	0	0	0	0	0	0	13,576	22
23	Inservice Training & Education	0	41,596	0	0	0	0	0	0	0	0	0	41,596	23
24	Travel and Seminar	0	2,491	0	0	0	0	0	0	0	0	0	2,491	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	0	54,930	0	0	0	0	0	0	0	0	54,930	27
28	**TOTAL General Administration**	(260,563)	689,428	(294,358)	6,665	0	0	0	0	0	0	0	141,172	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(262,465)	690,035	(294,358)	6,665	0	0	0	0	0	0	0	139,877	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number NORRIDGE HLTHCR & REHAB CENTRE # 32011 Report Period Beginning: 1-Jan-2011 Ending: 31-Dec-2011

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	(39,933)	13,923	0	418,738	0	0	0	0	0	0	0	392,728	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(58,961)	7,152	27,402	1,489,502	0	0	0	0	0	0	0	1,465,095	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	(2,484,000)	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	(98,894)	21,075	27,402	(575,760)	0	0	0	0	0	0	0	(626,177)	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)	(361,359)	711,110	(266,956)	(569,095)	0	0	0	0	0	0	0	(486,300)	45

Facility Name & ID Number NORRIDGE HLTHCR & REHAB CENTRE # 32011 Report Period Beginning: 1-Jan-2011 Ending: 31-Dec-2011

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as 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	19	Professional Services	$	Lancaster, Ltd.	100.00%	$ 24,913	$ 24,913	1
2	V	21	Clerical Expenses		Lancaster, Ltd.	100.00%	231,730	231,730	2
3	V	22	Employee Benefits		Lancaster, Ltd.	100.00%	13,576	13,576	3
4	V	24	Seminars and Travel		Lancaster, Ltd.	100.00%	2,491	2,491	4
5	V	17	Administrative Consulting		Lancaster, Ltd.	100.00%	232,584	232,584	5
6	V	20	Marketing Fees		Lancaster, Ltd.	100.00%	139,911	139,911	6
7	V	20	Dues, Fees & Subscriptions		Lancaster, Ltd.	100.00%	2,627	2,627	7
8	V	30	Depreciation		Lancaster, Ltd.	100.00%	13,923	13,923	8
9	V	6	Repairs and Maintenance		Lancaster, Ltd.	100.00%	607	607	9
10	V	23	Education & Inservice		Lancaster, Ltd.	100.00%	41,596	41,596	10
11	V	32	Interest Paid		Lancaster, Ltd.	100.00%	7,152	7,152	11
12	V								12
13	V								13
14	Total			$			$ 711,110	$ * 711,110	14

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

Facility Name & ID Number NORRIDGE HLTHCR & REHAB CENTRE # 32011 Report Period Beginning: 1-Jan-2011 Ending: 31-Dec-2011

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	17	Management Fee Income	$ 525,600	Lancaster, Ltd.	100.00%	$	$ (525,600)	15
16	V	17	Officers' Salaries		Lancaster, Ltd.	100.00%	176,312	176,312	16
17	V	27	Payroll Taxes-Officers		Lancaster, Ltd.	100.00%	7,815	7,815	17
18	V	27	Payroll Taxes-Staff		Lancaster, Ltd.	100.00%	47,115	47,115	18
19	V								19
20	V								20
21	V	32	**Direct Interest**		Lancaster, Ltd.		27,402	27,402	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			$ 525,600			$ 258,644	$ * (266,956)	39

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

Facility Name & ID Number NORRIDGE HLTHCR & REHAB CENTRE # 32011 Report Period Beginning: 1-Jan-2011 Ending: 31-Dec-2011

VII. RELATED PARTIES (continued)

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

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

1 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	10,498	Norridge Associates		1,500,000	1,489,502	16
17	V	30	Depreciation		Norridge Associates		418,738	418,738	17
18	V	19	Accounting Fees		Norridge Associates		2,250	2,250	18
19	V	21	State Replacement Tax		Norridge Associates		4,415	4,415	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			$ 2,494,498			$ 1,925,403	$ * (569,095)	39

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

Facility Name & ID Number NORRIDGE HLTHCR & REHAB CENTRI # 32011 Report Period Beginning: 1-Jan-2011 Ending: 31-Dec-2011

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	18	37.50	Lancaster	$ 69,406	17-7	1
2	Cheryl Morris	VP-Operations	Administrative		see attached	18	37.50	Lancaster	106,906	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	$ 176,312		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 HLTHCR & REHAB CENTRE # 32011 Report Period Beginning: 1-Jan-2011 Ending: -Dec-2011

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	$ 185,082	$ 185,082	18	$ 69,406	1
2	27	Christopher Vicere-Payroll tax	Hours Worked	48	4	9,705		18	3,639	2
3	17	Cheryl Morris	Hours Worked	48	4	285,082	285,082	18	106,906	3
4	27	Cheryl Morris-Payroll tax	Hours Worked	48	4	11,135		18	4,176	4
5										5
6										6
7	19	Professional Services	Census Days	249,635	4	62,108		100,137	24,913	7
8	21	Clerical Expenses	Census Days	249,635	4	577,688	544,818	100,137	231,730	8
9	22	Employee Benefits	Census Days	249,635	4	33,844		100,137	13,576	9
10	24	Seminars and Travel	Census Days	249,635	4	6,209		100,137	2,491	10
11	17	Administrative Consulting	Census Days	249,635	4	579,818	579,818	100,137	232,584	11
12	20	Marketing Fees	Census Days	249,635	4	348,790	346,861	100,137	139,911	12
13	20	Dues, Fees and Subscriptions	Census Days	249,635	4	6,548		100,137	2,627	13
14	30	Depreciation	Census Days	249,635	4	34,708		100,137	13,923	14
15	6	Repairs and Maintenance	Census Days	249,635	4	1,513		100,137	607	15
16	23	Education and Inservice	Census Days	249,635	4	103,695		100,137	41,596	16
17	32	Interest	Census Days	249,635	4	17,830		100,137	7,152	17
18	27	Payroll Taxes	Census Days	249,635	4	117,455		100,137	47,115	18
19										19
20										20
21										21
22	32	**Direct Interest**							27,402	22
23										23
24										24
25	TOTALS					$ 2,381,211	$ 1,941,661		$ 969,754	25

Facility Name & ID Number NORRIDGE HLTHCR & REHAB CENTRE # 32011 Report Period Beginning: 1-Jan-2011 Ending: 31-Dec-2011

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		X	Working Capital							7,152	7
8												8
9	TOTAL Facility Related						$	$			$ 1,507,152	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 1,507,152	15

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

Set-Off Interest Income (42,057)

1,465,095

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 HLTHCR & REHAB CENTRE **#** 32011 **Report Period Beginning:** 1-Jan-2011 **Ending:** 31-Dec-2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 746,000	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.)		$ 730,568	2
3. Under or (over) accrual (line 2 minus line 1).		$ (15,432)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 752,000	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.		$ 736,568	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	506,138	8
	2007	535,993	9
	2008	564,066	10
	2009	704,478	11
	2010	730,568	12

** Accrual is based on 2010 Taxes, adjusted for inflation**

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME NORRIDGE HLTHCR & REHAB CENTRE COUNTY Cook

FACILITY IDPH LICENSE NUMBER 32011

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 2010 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 2010.

	(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	$ 187,214.38	$ 187,214.38
2.	13-18-318-006-000	Long-Term Healthcare	$ 178,728.66	$ 178,728.66
3.	13-18-318-007-0000	Long-Term Healthcare	$ 180,238.89	$ 180,238.89
4.	13-18-318-008-0000	Long-Term Healthcare	$ 184,385.79	$ 184,385.79
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 730,567.72	$ 730,567.72

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 HLTHCR & REHAB CENTRE # 32011 Report Period Beginning: 1-Jan-2011 Ending: 31-Dec-2011

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: None
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

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 HLTHCR & REHAB CENTRE # 32011 Report Period Beginning: 1-Jan-2011 Ending: 31-Dec-2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		838,781	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	43,548	1,381	20		(1,381)	43,548	9
10	Various			1988	3,940	124	20		(124)	3,940	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		(121)	3,827	13
14	Various			1990	28,644	909	20		(909)	28,644	14
15	Various			1991	72,916	2,314	20	2,357	43	72,916	15
16	Various			1992	36,639	950	20	1,497	547	35,975	16
17	Various			1993	72,513	1,920	20	3,624	1,704	67,538	17
18	Various			1994	116,353	2,938	20	5,727	2,789	101,566	18
19	Various			1995	95,409	2,447	20	4,770	2,323	80,803	19
20	Boiler/Hot Water Heater Improvements			1996	9,417	241	20	471	230	7,534	20
21	Tuckpointing			1999	28,900	741	20	1,445	704	18,183	21
22	Architect Fee 1st Floor			2001	15,052	386	39	386		4,197	22
23	Construction 1st Floor			2001	166,662	4,273	39	4,273		46,473	23
24	Constrution Library			2001	12,461	320	39	320		3,475	24
25	Design Fee-1st Floor			2001	5,130	132	39	132		1,431	25
26	Sprinklers-1st Floor			2001	4,531	116	39	116		1,262	26
27	Demolition-1st Floor			2001	5,533	142	39	142		1,543	27
28	Wooden Doors (2)			2001	1,134	29	39	29		316	28
29	Construction Work			2002	4,207	108	39	108		1,110	29
30	Smoking Shelter			2002	3,251	83	10	325	242	3,250	30
31	Auto Front Door			2002	2,074	53	10	207	154	1,988	31
32	Fence In Lot			2003	2,972	88	15	198	110	1,634	32
33	Building New-Town Square			2003	281,539	16,610	15	19,508	2,898	159,314	33
34	Roofing			2003	62,440	1,601	39	6,244	4,643	50,993	34
35	Wanderguard			2004	964		10	96	96	754	35
36	Refuse Inclosure			2004	2,395		10	240		1,756	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 HLTHCR & REHAB CENTRE # 32011 Report Period Beginning: 1-Jan-2011 Ending: 31-Dec-2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$	7	$ 3,729	$ 3,729	$ 104,399	37
38	Patio Concrete	2004	2,500	64	39	250	186	1,979	38
39	Air Ventilation System	2004	26,794	687	39	2,233	1,546	16,932	39
40	Design & Development of Town Square	2004	42,130	1,080	39	4,213	3,133	33,002	40
41	Consultancy Fire Alarm Installation	2004	22,700		7	810	810	22,700	41
42	Hand Rail System	2005	6,025	154	10	603	449	4,119	42
43	Duct Detectors	2005	2,061	53	5		(53)	2,061	43
44	20 Ton Roof Top Aircon	2005	17,635	452	5		(452)	17,635	44
45	Elevator Fire Upgrade	2005	46,440	1,191	5		(1,191)	46,440	45
46	Concrete Approach Pad	2005	2,160	55	10	216	161	1,386	46
47	27 Plastic Laminate Doors	2006	6,145	158	10	615	457	3,585	47
48	10T Rooftop A/C W/Exhaust	2006	24,668	632	10	2,467	1,835	13,773	48
49	Wanderguard	2006	1,000	26	10	100	74	517	49
50	Laminate 2x Egress Doors	2007	4,361	112	10	436	324	2,035	50
51	Electrical Fittings, Fixtures & Holders 2nd Floor	2007	6,512	167	39	651	484	2,767	51
52	Construction Cost-2nd Floor & Dementia Unit	2007	294,274	7,546	39	29,427	21,881	125,065	52
53	Architechtural Cost-2nd Floor & Dementia Unit	2007	13,657	350	39	1,366	1,016	5,805	53
54	Wallcoverings,Borders,Accent Tiles,Murals-2nd FL	2007	41,777	1,071	39	4,178	3,107	17,757	54
55	Fixtures & Fittings Incl.countertops,Sinks&Blinds	2007	56,845	1,457	39	5,684	4,227	24,157	55
56	Glazed/Unglazed Vinyl/Ceramic Tiles&Floor Coverings	2007	34,919	895	39	3,492	2,597	14,841	56
57	Cabinetry For 2nd Floor & Dementia Unit	2007	96,950	10,606	5	19,390	8,784	82,408	57
58	Bed Annunciator Panel	2009	12,900	1,238	5	2,580	1,342	6,665	58
59	Islandaire Unit	2009	14,722	377	10	1,472	1,095	3,803	59
60	Replacement of Boilers	2009	97,850	2,509	10	9,785	7,276	22,016	60
61	New Gas Pipe Laid	2009	3,247	83	10	325	242	731	61
62	New Door	2009	1,552	40	10	155	115	336	62
63	30 x Signalling Boxes	2009	1,023	98	5	205	107	426	63
64	Architechtural & CAD Services, Permit/License Fee-4th Floor	2009	7,010	180	39	701	521	1,753	64
65	Remove & Rebuild walls,Tiles,Plumbing,Lights-4th Floor	2009	157,001	4,026	39	15,700	11,674	39,250	65
66	Cabinet,Counter,Wall/Window treatment-Activity Rm-4th Flr	2009	14,122	1,356	5	1,412	56	3,530	66
67	Shower Room w/lights,tiles,mirror,vanity,Heat lamps-4th Flr	2009	7,109	182	39	711	529	1,777	67
68	Built-in wooden File cabinet with doors-Nursing Area-4th Flr	2009	13,250	1,272	5	1,325	53	3,313	68
69	Built-in Display Unit w/molding & Pilasters-Music Area-4th Flr	2009	6,120	588	5	612	24	1,530	69
70	TOTAL (lines 4 thru 69)		$ 12,822,146	$ 119,009		$ 208,835	$ 89,586	$ 11,445,115	70

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

Facility Name & ID Number NORRIDGE HLTHCR & REHAB CENTRE # 32011 Report Period Beginning: 1-Jan-2011 Ending: 31-Dec-2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 12,822,146	$ 119,009		$ 208,835	$ 89,826	$ 11,445,115	1
2	Acoustical Ceiling Tiles on 4th Floor	2009	24,998	641	39	2,500	1,859	6,250	2
3	Light Fixtures for Central Area on 4th Floor	2009	14,447	370	39	1,445	1,075	3,612	3
4	Corner Guards, rails, Carpets,Cabinets-Central Area-4th Flr	2009	36,047	3,461	5	3,605	144	9,012	4
5	Tiles, Counter Tops, Corner Guards,Sink, cabinets-4th Floor	2009	21,854	2,098	5	4,371	2,273	10,927	5
6	Wall Protection Material & Adhesive - 4th Floor	2009	21,860	2,099	5	4,372	2,273	10,930	6
7	Architectural/Structural Srvcs,Alarm & Permit fees-PT Room	2010	43,732	1,121	39	4,373	3,252	8,382	7
8	Construction,Fire Alarm,Ceiling,Plumbing-New PT Room	2010	455,459	11,678	39	45,546	33,868	87,296	8
9	Steel Stairs & Hand rails Installed in New PT Room	2010	7,245	186	39	725	539	1,389	9
10	RPZ, Sprinkler & Fire Alarm System Installed in PT Room	2010	31,766	814	39	3,177	2,363	6,088	10
11	Glass Installed on Walls of PT Room	2010	30,180	774	39	3,018	2,244	5,785	11
12	Heating/Cooling Installation & Exterior Insulation-PT Room	2010	74,470	1,909	39	7,447	5,538	14,273	12
13	Floor Tiles,Painting,Mural,Molding,Ceiling Lights-PT Room	2010	72,811	1,867	39	7,281	5,414	13,955	13
14	Electrical Lines to Laundry Section	2010	23,166	3,707	5	4,633	926	8,108	14
15	Physical Therapy Room Wall cabinets	2010	5,700	912	5	1,140	228	1,805	15
16	Counter Fire Steel Reinforced Doors	2010	8,140	209	10	814	605	1,221	16
17	Laundry Room Air Conditioning System	2010	10,900	1,744	5	2,180	436	3,088	17
18	Kitchen Refrigeration System	2010	13,560	2,170	5	2,712	542	3,616	18
19	Architectural/Structural Services & Alarm-Alzheimer's Unit	2011	35,904	269		1,197	928	1,197	19
20	Structural Strengthening & Construction - Alzheimer's Unit	2011	615,852	4,613		20,528	15,915	20,528	20
21	Wallpaper,Vinyl flooring,Carpet,Cabinets-Alzheimer's Unit	2011	192,466	192,466		12,831	(179,635)	12,831	21
22	Acoustical Tiled Ceiling & Grid - Alzheimer's Unit (3rd Flr)	2011	5,000	37		167	130	167	22
23	Constructing RoofTop Patio with Safety Bumpers & Railings	2011	26,824	201		894	693	894	23
24	Water Fountain,Swing Bench,Artificial Plants-Rooftop Patio	2011	17,381	17,381		1,159	(16,222)	1,159	24
25	5 Digital Telephones for Exiting System	2011	1,102	1,102		184	(918)	184	25
26	Fire Alarm System	2011	7,900	161		658	497	658	26
27	Washer/Dryer & Cooktop with Hood for 3rd Floor	2011	3,778	3,778		630	(3,148)	630	27
28	Sprinkler System for Elevator Room & Cooler room	2011	15,534	283		1,165	882	1,165	28
29	Sprinkler System for 3rd Floor Bath Rooms	2011	15,475	215		903	688	903	29
30	Exterior Masonary work,Caulking & Painting whole Building	2011	93,000			3,875	3,875	3,875	30
31	Wall Cabinets & Closet for 3rd Floor Activity Room	2011	2,508	2,508		167	(2,341)	167	31
32	Install Fire Command Box & KeyPads on 3rd Floor	2011	8,765	28		146	118	146	32
33									33
34	TOTAL (lines 1 thru 33)		$ 14,759,970	$ 377,811		$ 352,678	$ (25,133)	$ 11,685,356	34

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

Facility Name & ID Number NORRIDGE HLTHCR & REHAB CENTRE # 32011 Report Period Beginning: 1-Jan-2011 Ending: 31-Dec-2011

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 948,147	$ 99,443	$ 205,838	$ 106,395	7	$ 614,183	71
72	Current Year Purchases	141,154	144,154	14,543	(129,611)	7	14,543	72
73	Fully Depreciated Assets	2,203,456	5,438	13,854	8,416	7	2,203,456	73
74	**Lancaster Allocation**		13,923	13,923			55,069	74
75	TOTALS	$ 3,292,757	$ 262,958	$ 248,158	$ (14,800)		$ 2,887,251	75

D. Vehicle Costs. (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)	$ 18,829,515	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 640,769	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 600,836	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (39,933)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 14,572,607	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 HLTHCR & REHAB CENTRE # 32011 Report Period Beginning: 1-Jan-2011 Ending: 31-Dec-2011

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:	***Leased from a Related Party***			$			3
4	Additions							4
5		***Off-site Public Storage***			8,277			5
6								6
7	TOTAL				$ 8,277 **			7

8. List separately any amortization of lease expense included on page 4, line 34. None
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

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.	/2012	$
13.	/2013	$
14.	/2014	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] 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	None				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 HLTHCR & REHAB CENTRE # 32011 Report Period Beginning: 1-Jan-2011 Ending: 31-Dec-2011

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	$	$ 2,340	$	$ 2,340
2	Books and Supplies	43	558		601
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	$ 43	$ 2,898	$	$ 2,941
10	SUM OF line 9, col. 1 and 2 (e)	$ 2,941			

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	39
2. From other facilities (f)	1
DROP-OUTS	
1. From this facility	3
2. From other facilities (f)	
TOTAL TRAINED	43

(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 HLTHCR & REHAB CENTRE # 32011 Report Period Beginning: 1-Jan-2011 Ending: 31-Dec-2011

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	$		$ 791,303	$		$ 791,303	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			235,981			235,981	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			836,716			836,716	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation **Inhalation Therapy*	39-3	hrs			9,301			9,301	8
9	Pharmacy	39-2	# of prescrpts				737,068		737,068	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): **Medical Supplies**	39-2					103,387		103,387	12
13	Other (specify): **Speciality Beds**	39-2					63,429		63,429	13
14	TOTAL			$		$ 1,873,301	$ 903,884		$ 2,777,185	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 HLTHCR & REHAB CENTRE # 32011 Report Period Beginning: 1-Jan-2011 Ending: 31-Dec-2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 31-Dec-2011 (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	$ 95,035	$ 95,035	1
2	Cash-Patient Deposits	108,177	108,177	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	6,643,566	6,643,566	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	77,427	77,427	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	514,915	2,734,734	8
9	Other(specify): ** Refundable Deposits**	6,200	6,200	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 7,445,320	$ 9,665,139	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	1,126,661	4,147,006	15
16	Equipment, at Historical Cost	2,594,218	3,292,760	16
17	Accumulated Depreciation (book methods)	(2,942,803)	(14,480,739)	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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 878,076	$ 4,355,780	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,323,396	$ 14,020,919	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 666,446	$ 680,237	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	124,955	124,955	28
29	Short-Term Notes Payable	419,597	419,597	29
30	Accrued Salaries Payable	800,440	800,440	30
31	Accrued Taxes Payable (excluding real estate taxes)	30,790	30,790	31
32	Accrued Real Estate Taxes(Sch.IX-B)	752,000	752,000	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)**	$ 2,794,228	$ 2,808,019	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)**	$ 2,794,228	$ 17,808,019	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,529,168	$ (3,787,100)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,323,396	$ 14,020,919	48

***(See instructions.)**

Facility Name & ID Number NORRIDGE HLTHCR & REHAB CENTRE # 32011 Report Period Beginning: 1-Jan-2011 Ending: 31-Dec-2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,881,857	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,881,857	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,034,558	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)**	$ 647,311	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)**	$ 5,529,168	24 *

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

Facility Name & ID Number NORRIDGE HLTHCR & REHAB CENTRE # 32011 **Report Period Beginning:** 1-Jan-2011 **Ending:** 31-Dec-2011

XVI. STATEMENT OF CHANGES IN EQUITY

		Total after consolidation	
1	**Balance at Beginning of Year, as Previously Reported**	$ (5,003,506)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (5,003,506)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,603,653	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)**	$ 1,216,406	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)**	$ (3,787,100)	24 *

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

Facility Name & ID Number NORRIDGE HLTHCR & REHAB CENTRE # 32011 Report Period Beginning: 1-Jan-2011 Ending: 31-Dec-2011

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	$ 28,239,757	1
2	Discounts and Allowances for all Levels	(8,720,644)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 19,519,113	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,409,133	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,409,133	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	725,970	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,090	19
20	Radiology and X-Ray	55,776	20
21	Other Medical Services	143,797	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 936,633	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	58,961	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 58,961	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	** Vending Commissions **	3,000	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,000	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 24,926,840	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	3,443,415	31
32	Health Care	8,204,503	32
33	General Administration	3,537,750	33
	B. Capital Expense		
34	Ownership	3,436,953	34
	C. Ancillary Expense		
35	Special Cost Centers	2,777,185	35
36	Provider Participation Fee	159,870	36
	D. Other Expenses (specify):		
37	**Additional State Fee @$6.07**	332,606	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 21,892,282	40
41	**Income before Income Taxes (line 30 minus line 40)****	3,034,558	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 3,034,558	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. **Set off on Pg 9 & 5**

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

Facility Name & ID Number NORRIDGE HLTHCR & REHAB CENTRE # 32011 Report Period Beginning: 1-Jan-2011 Ending: 31-Dec-2011

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	2,046	2,276	$ 121,783	$ 53.51	1
2	Assistant Director of Nursing	5,152	5,938	231,203	38.94	2
3	Registered Nurses	83,156	88,847	2,588,294	29.13	3
4	Licensed Practical Nurses	37,057	38,638	977,165	25.29	4
5	CNAs & Orderlies	226,900	245,890	2,757,738	11.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,969	2,206	51,080	23.16	9
10	Activity Assistants	17,065	18,435	209,336	11.36	10
11	Social Service Workers	11,325	12,231	182,283	14.90	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	56,256	62,392	789,148	12.65	15
16	Dishwashers					16
17	Maintenance Workers	6,231	6,707	131,420	19.59	17
18	Housekeepers	38,863	42,841	491,749	11.48	18
19	Laundry	18,902	20,938	214,886	10.26	19
20	Administrator	1,837	2,086	121,102	58.05	20
21	Assistant Administrator	1,973	2,150	59,114	27.49	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	23,060	25,207	427,505	16.96	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	7,677	8,358	98,075	11.73	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	539,469	585,140	$ 9,451,881 *	$ 16.15	34

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

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	710	$ 23,275	1-3	35
36	Medical Director	1,000	35,000	9-3	36
37	Medical Records Consultant	167	4,512	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	556	18,359	10-3	39
40	Physical Therapy Consultant	2,650	86,736	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	438	11,371	11-3	44
45	Social Service Consultant	209	6,285	12-3	45
46	Other(specify)				46
47	**Dementia Consultant**	3	80	10a-3	47
48					48
49	TOTAL (lines 35 - 48)	5,733	$ 185,618		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	98	$ 4,410	10-3	50
51	Licensed Practical Nurses	16	480	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	114	$ 4,890		53

** See instructions.

Facility Name & ID Number NORRIDGE HLTHCR & REHAB CENTRE # 32011 Report Period Beginning: 1-Jan-2011 Ending: 31-Dec-2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Safet Keljalic	Administrator	N/A	$ 121,102
Jina Lebert-Davies	Asst. Administrator	N/A	59,114
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 180,216

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
Health Data Systems, Inc.	Data Processing	$ 10,999
Medifax-EDI, LLc	Data Processing	1,746
E-Health Solutions Inc	Data Processing	73,836
Towerstream Corporation	Data Processing	1,000
CDW Government Inc.	Data Processing	1,146
Sprint Plc	Data Processing	898
Providigm, LLc.	Data Processing	210
Richard Peelo & Associates	Accounting	2,250
Frost Ruttenberg & Rothblatt	Accounting	1,750
Personnel Planners, Inc.	Payroll Tax Consultant	2,468
Law Office of Carter Korey	Legal	17,696
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 113,999

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 121,550
Unemployment Compensation Insurance	113,576
FICA Taxes	704,138
Employee Health Insurance	460,438
Employee Meals	35,937
Illinois Municipal Retirement Fund (IMRF)*	
Miscellaneous Employee Benefits	33,437
Uniform Allowance	12,398
Retirement Plan Contribution	84,272
Dental Insurance	22,169
Employment Fees	32,909
Lancaster Allocation	13,576
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,634,400

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	2,372
Health Care Worker Background Check	
(Indicate # of checks performed 359)	7,275
Patient Background Checks 241	3,720
Licenses & Fees	2,085
Promotional Advertising	33,201
Contributions	850
Lancaster Allocation	142,538
Less: Public Relations Expense	(3,850)
Non-allowable advertising	(170,112)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,069

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	5,128
Lancaster Allocation	293
Seminar Expense	11,227
Lancaster Allocation	2,198
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 18,846

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number NORRIDGE HLTHCR & REHAB CENTRE # 32011 Report Period Beginning: 1-Jan-2011 Ending: 31-Dec-2011

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	Painting & Decorating	Mar-2011	2,270	3					757	756	757		
7	Painting & Decorating	Nov-2011	2,475	3					412	825	825	413	
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 13,533		$ 54	$ 128	$ 459	$ 2,241	$ 3,766	$ 3,848	$ 2,040	$ 413	$

Facility Name & ID Number NORRIDGE HLTHCR & REHAB CENTRE **#** 32011 **Report Period Beginning:** 1-Jan-2011 **Ending:** 31-Dec-2011

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(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? **12 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **123,938** Line **10-2**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **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? **N/A** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **35,937** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **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.