

		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: 0047241

Facility Name: CLARIDGE HEALTHCARE CENTER

Address: 700 JENKISSON AVENUE LAKE BLUFF 60044
Number City Zip Code

County: LAKE

Telephone Number: (847) 295-3900 Fax # (847) 295-3989

HFS ID Number:

Date of Initial License for Current Owners: 07/01/2005

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

X

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:
Name: BOB KAGDA Telephone Number: (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2011 to 12/31/2011 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)

(Type or Print Name) CHOON CHI

(Title) MEMBER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT)

(Print Name and Title) BOB KAGDA VICE PRESIDENT

(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON, LINCOLNWOOD, IL 60712-1124

(Telephone) (847) 675-3585 Fax # (847) 675-5777

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 CLARIDGE HEALTHCARE CENTER

0047241 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	160	Skilled (SNF)	160	58,400	1
2		Skilled Pediatric (SNF/PED)			2
3	71	Intermediate (ICF)	71	25,915	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	231	TOTALS	231	84,315	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	8,785	883	2,136	11,804	8
9	SNF/PED					9
10	ICF	21,428	1,224		22,652	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,213	2,107	2,136	34,456	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 40.87%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

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

NONE

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 07/01/05

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 07/01/05 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 42 and days of care provided 2,136

Medicare Intermediary NATIONAL GOVERNMENT SERVICES INC

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **CLARIDGE HEALTHCARE CENTER** # **0047241** Report Period Beginning: **01/01/2011** Ending: **12/31/2011**

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	187,062	12,999	8,367	208,428		208,428		208,428			1
2	Food Purchase		146,480		146,480		146,480		146,480			2
3	Housekeeping	107,112	16,838		123,950		123,950		123,950			3
4	Laundry		4,263		4,263		4,263		4,263			4
5	Heat and Other Utilities			127,275	127,275		127,275		127,275			5
6	Maintenance	24,035	70,238	30,555	124,828		124,828		124,828			6
7	Other (specify):*			11,582	11,582		11,582		11,582			7
8	TOTAL General Services	318,209	250,818	177,779	746,806		746,806		746,806			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	759,534	88,376	851,498	1,699,408		1,699,408	(833,777)	865,631			10
10a	Therapy											10a
11	Activities	53,137	809		53,946		53,946		53,946			11
12	Social Services	18,380		3,081	21,461		21,461		21,461			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	831,051	89,185	890,579	1,810,815		1,810,815	(833,777)	977,038			16
	C. General Administration											
17	Administrative	39,968			39,968		39,968		39,968			17
18	Directors Fees											18
19	Professional Services			59,214	59,214		59,214		59,214			19
20	Dues, Fees, Subscriptions & Promotions			16,172	16,172		16,172	(11,896)	4,276			20
21	Clerical & General Office Expenses	53,503	18,542	47,449	119,494		119,494	(7,863)	111,631			21
22	Employee Benefits & Payroll Taxes			168,924	168,924		168,924		168,924			22
23	Inservice Training & Education			555	555		555		555			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			3,009	3,009		3,009		3,009			25
26	Insurance-Prop.Liab.Malpractice			139,962	139,962		139,962	9,983	149,945			26
27	Other (specify):*			60,000	60,000		60,000	(60,000)				27
28	TOTAL General Administration	93,471	18,542	495,285	607,298		607,298	(69,776)	537,522			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,242,731	358,545	1,563,643	3,164,919		3,164,919	(903,553)	2,261,366			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.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	8,367
	REPAIRS & MAINTENANCE	0
		0
		8,367
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	40,383
	ELECTRICITY	56,133
	WATER	30,759
	CABLE TV - LOBBY	0
		0
		127,275
6	MAINTENANCE	
	GROUNDS MAINTENANCE	10,515
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	6,088
	ELEVATOR MAINTENANCE & REPAIR	3,642
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,463
	FIRE SERVICE	5,847
		0
		0
		0
		0
		30,555
7	OTHER	
	SCAVENGER	11,582
	SECURITY SERVICE	0
		0
		0
		11,582
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	36,000
		36,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	833,777
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B -2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	6,336
	UTILIZATION REVIEW FEES XVIII B -2	0
	PHYSICIANS XVIII B -2	0
	PSYCHIATRIC XVIII B -2	0
	RN CONSULTANT XVIII B 38-2	0
	MDS CONSULTANT	11,385
		0
		851,498
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B -2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	3,081
	SOCIAL WORKER XVIII B 45-2	0
		3,081
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION		0
			0
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B	0
	DIRECTORS FEES		
18	DIRECTORS FEES		0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C	13,618
	ADMINISTRATIVE CONSULTANTS	XIX C	0
	PROFESSIONAL FEES	XIX C	45,596
			0
			59,214
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	11,396
	EMPLOYEE WANT ADS	XIX F	0
	CONTRIBUTIONS	VI 20 XIX F	0
	DUES & SUBSCRIPTIONS	XIX F	420
	LICENSES & PERMITS	XIX F	3,326
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	500
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	80
	PATIENT BACKGROUND CHECKS	XIX F	450
			16,172
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		200
	EQUIPMENT REPAIR & MAINTENANCE		0
	OUTSIDE CLERICAL SERVICES		30,205
	PENALTIES / OVERDRAFT CHARGES	VI 18	7,863
	HOME OFFICE EXPENSE		0
	THEFT & DAMAGE LOSS		0
	TELEPHONE		9,181
	MESSENGER SERVICE		0
			0
			47,449

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D	100,069
	UNEMPLOYMENT COMPENSATION	XIX D	20,938
	WORKERS COMPENSATION INSURANC	XIX D	47,917
	HOSPITALIZATION INSURANCE	XIX D	0
	EMPLOYEE BENEFITS - OTHER	XIX D	0
	EMPLOYEE PHYSICAL EXAMS	XIX D	0
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS	XIX D	0
	CHICAGO HEAD TAX	XIX D	0
			0
			168,924
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS		555
			555
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G	0
	TRAVEL	XIX G	0
			0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF		3,009
			3,009
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE		139,962
			139,962
27	OTHER		
	BAD DEBTS	VI 24	60,000
			60,000

GRAND TOTAL COLUMN 3 OTHER

1,563,643

CLARIDGE HEALTHCARE CENTER
SCHEDULES
12/31/2011

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	146,480	
LESS SALES TAX	0	HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??
NET FOOD	146,480	
TOTAL PATIENT CENSUS	34,456	
TIME 3 MEALS PER DAY	3	
TOTAL PATIENT MEALS	103,368	
ADD # EMPLOYEE MEALS/DAY	0	
TIME # DAYS	365	
TOTAL EMPLOYEE MEALS	0	
PATIENT MEALS	103,368	
ADD EMPLOYEE MEALS	0	
TOTAL MEALS/YEAR	103,368	
NET FOOD	146,480	
DIVIDE TOTAL MEALS/YEAR	103,368	
COST PER MEAL	1.42	
TIME EMPLOYEE MEALS	0	
EMPLOYEE MEAL RECLASSIFICATION	0	
	=====	

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			27,613	27,613		27,613	255,395	283,008			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			86,357	86,357		86,357	542,738	629,095			32
33	Real Estate Taxes							120,663	120,663			33
34	Rent-Facility & Grounds			960,000	960,000		960,000	(960,000)				34
35	Rent-Equipment & Vehicles			5,461	5,461		5,461		5,461			35
36	Other (specify):*							32,933	32,933			36
37	TOTAL Ownership			1,079,431	1,079,431		1,079,431	(8,271)	1,071,160			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		58,403	160,530	218,933		218,933		218,933			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee				126,473		126,473		126,473			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		58,403	160,530	345,406		345,406		345,406			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,242,731	416,948	2,803,604	4,589,756		4,589,756	(911,824)	3,677,932			45

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

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	10,148	30		9
10	Interest and Other Investment Income	(332)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest	(24)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(500)	20		17
18	Fines and Penalties	(7,863)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,000)	27		24
25	Fund Raising, Advertising and Promotional	(11,396)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (69,967)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(841,857)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (841,857)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (911,824)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID#0047241

Report Period Beginning:01/01/2011

Ending:12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DEFERRED MAINTENANCE	\$	6
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CLARIDGE HEALTHCARE CENTER # 0047241 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	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	(833,777)	0	0	0	0	0	0	0	0	0	(833,777)	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	(833,777)	0	0	0	0	0	0	0	0	0	(833,777)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(11,896)	0	0	0	0	0	0	0	0	0	0	(11,896)	20
21	Clerical & General Office Expenses	(7,863)	0	0	0	0	0	0	0	0	0	0	(7,863)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	9,983	0	0	0	0	0	0	0	0	0	9,983	26
27	Other (specify):*	(60,000)	0	0	0	0	0	0	0	0	0	0	(60,000)	27
28	TOTAL General Administration	(79,759)	9,983	0	0	0	0	0	0	0	0	0	(69,776)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(79,759)	(823,794)	0	0	0	0	0	0	0	0	0	(903,553)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CLARIDGE HEALTHCARE CENTER # 0047241 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	10,148	245,247	0	0	0	0	0	0	0	0	0	255,395	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(356)	543,094	0	0	0	0	0	0	0	0	0	542,738	32
33	Real Estate Taxes	0	120,663	0	0	0	0	0	0	0	0	0	120,663	33
34	Rent-Facility & Grounds	0	(960,000)	0	0	0	0	0	0	0	0	0	(960,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	32,933	0	0	0	0	0	0	0	0	0	32,933	36
37	TOTAL Ownership	9,792	(18,063)	0	0	0	0	0	0	0	0	0	(8,271)	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)	(69,967)	(841,857)	0	0	0	0	0	0	0	0	0	(911,824)	45

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
MRS CHOON CHI	96			CLARIDGE REAL		
RICHARD SCOTT O'BRIEN	4			ESTATE, LLC	LAKE BLUFF	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	\$ 960,000	CLARIDGE REAL ESTATE LLC	100.00%	\$	(960,000)	1
2	V								2
3	V	26	INSURANCE				9,983	9,983	3
4	V	33	REAL ESTATE TAXES				120,663	120,663	4
5	V	32	INTEREST				543,094	543,094	5
6	V	36	MIP INSURANCE				32,933	32,933	6
7	V	30	DEPRECIATION				245,247	245,247	7
8	V								8
9	V								9
10	V								10
11	V	10	CONTRACT NURSING	833,777	PNI	100.00%		(833,777)	11
12	V								12
13	V								13
14	Total			\$ 1,793,777			\$ 951,920	\$ * (841,857)	14

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MRS CHOON CHI	ADMINISTRATIVE		96.00					\$		1
2	RICHARD SCOTT O'BRIEN	CFO		4.00							2
3	ALEXANDER CHI	ASST ADMIN/ADMISSIONS				40	100.00	SALARY	39,968	17-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 39,968		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 CLARIDGE HEALTHCARE CENTER # 0047241 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (_____
Fax Number (_____

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$			25

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense				
		YES	NO				Original	Balance							
	A. Directly Facility Related														
	Long-Term														
1	RELATED PARTY: CLARIDGE REAL ESTATE, LLC						\$				\$	1			
2	HEARTLAND BANK		X	MORTGAGE	\$75,742.00	05/27/94		8,192,800	6,594,233	06/01/29	8.1250	543,094	2		
3													3		
4													4		
5													5		
	Working Capital														
6	CHOON CHI & S O'BRIEN		X	WORKING CAPITAL								82,907	6		
7													7		
8			X	INSURANCE FINANSING								3,426	8		
9	TOTAL Facility Related				\$75,742.00		\$	8,192,800	\$	6,594,233		\$	629,427	9	
	B. Non-Facility Related*														
10	IRS											24	10		
11													11		
12													12		
13													13		
14	TOTAL Non-Facility Related						\$		\$			\$	24	14	
15	TOTALS (line 9+line14)							\$	8,192,800	\$	6,594,233		\$	629,451	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.

\$ 32,933

Line # 36

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

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

HFS 3745 (N-4-99)

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.	\$	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.)			\$120,663	2
3. Under or (over) accrual (line 2 minus line 1).			\$120,663	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	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.			\$120,663	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2006	145,837	8	
	2007	142,704	9	
	2008	149,663	10	
	2009	157,296	11	
	2010	120,663	12	
				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
THE PAYMENT ON LINE 2 APPLIES TO THE 2010 TAX BILL.				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

CLARIDGE HEALTHCARE CENTER

COUNTY

LAKE

FACILITY IDPH LICENSE NUMBER

0047241

CONTACT PERSON REGARDING THIS REPORT

BOB KAGDA

TELEPHONE

(847) 675-3585

FAX #:

(847) 675-5777

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)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>12-18-400-003</u>	<u>NURSING HOME</u>	\$ <u>1,935.16</u>	\$ <u>1,935.16</u>
2. <u>12-18-400-010</u>	<u>NURSING HOME</u>	\$ <u>118,727.45</u>	\$ <u>118,727.45</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>120,662.61</u></u>	\$ <u><u>120,662.61</u></u>

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 providecopies of their original **second installment** tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 58,545

B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 3

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☐ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME		2005	\$ 885,703	1
2					2
3	TOTALS			\$ 885,703	3

Facility Name & ID Number CLARIDGE HEALTHCARE CENTER

0047241

Report Period Beginning:

01/01/2011 Ending: 12/31/2011

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		RELATED PARTY: CLARIDGE REAL ESTATE, LLC			\$	\$		\$	\$		4
5	231		2005		7,552,808	193,662	39	193,662			5
6			2005		515,849	51,585	10	51,585			6
7											7
8											8
	Improvement Type**										
9		PAINTING; TILE & WALLPAPER COVERING; CEILING TILE	2005		52,239	1,900	27.5	1,900		11,954	9
10		FLOORING, COVE BASE, CARPETING	2005		57,519	2,091	27.5	2,091		13,157	10
11		STEEL DOORS	2005		16,319	593	27.5	593		3,731	11
12		PLUMBING REPAIRS; PUMPS, VALUES, MOTORS	2005		19,662	715	27.5	715		4,499	12
13		SPRINKLER SYS;SMOKE DET; FIRE DAMPER;TEMP CONTR	2005		25,043	911	27.5	911		5,729	13
14		LOBBY COUNTER & NURSES STATION	2005		10,758	391	27.5	391		2,460	14
15		WINDOW TREATMENT; CUBICLE CURTAINS	2005		19,636	714	27.5	714		4,492	15
16		NEW SERVICES SIDEWALK	2005		2,400	87	27.5	87		548	16
17		INSULATION	2005		7,194	262	27.5	262		1,647	17
18		HANDRAILS	2006		15,358	558	27.5	558		3,046	18
19		CEILING TILES	2006		4,309	157	27.5	157		857	19
20		FIRE INSULATIONS	2006		4,400	160	27.5	160		873	20
21		FIRE ALARM SYSTEM	2007		31,590	1,149	27.5	1,149		5,123	21
22		HEATING AND AIR CONDITIONER REPAIRS	2007		26,295	956	27.5	956		4,263	22
23		WATER MAIN AND PARKING LOT REPAIR	2009		9,915	361	27.5	361		857	23
24		INSTALL NEW SEWER PIPE	2010		6,000	218	27.5	218		318	24
25		SPRINKLER SYS;SMOKE DET; FIRE DAMPER;TEMP CONTR	2010		8,570	312	27.5	312		455	25
26		REPLACED GFI OUTLETS;ELECTRIC BREAKERS IN PANEL	2010		4,398	160	27.5	160		233	26
27		REPLACED FLAME SAFEGUARDS ON BOILERS	2011		12,403	432	27.5	432		432	27
28		ROOF-PARAPET WALL;FLASHING;ROOF CEMENT;AWNING	2011		7,535	148	27.5	148		148	28
29		INSTALLED THE NEW GENERATOR CONTROLLER	2011		4,757	50	27.5	50		50	29
30		REPLACE VALVES ON TRANSFER PUMPS IN BOILER ROOM	2011		4,172	32	27.5	32		32	30
31											31
32											32
33											33
34											34
35											35
36											36

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 8,419,129	\$ 257,604		\$ 257,604	\$	\$ 64,904	70

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

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	\$249,044	\$5,256	\$24,904	\$19,648	10 YRS	\$149,120	71
72	Current Year Purchases	10,000	10,000	500	(9,500)	10YRS	500	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$259,044	\$15,256	\$25,404	\$10,148		\$149,620	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	2	
	Reference	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)	\$9,563,876	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$272,860	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$283,008	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$10,148	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$214,524	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - 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. ☐ YES ☐ NO

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

**

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 5,461 Description: SEE SCHEDULE ATTACHED
(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			N/A		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:

Fiscal Year EndingAnnual Rent
12. /2012 \$
13. /2013 \$
14. /2014 \$

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ 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
IN OTHER FACILITY
COMMUNITY COLLEGE
HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM
IN OTHER FACILITY
HOURS PER CNA

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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	\$		\$ 85,050	\$		\$ 85,050	1
2	Licensed Speech and Language Development Therapist	39-3	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			75,480			75,480	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				58,403		58,403	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$ 160,530	\$ 58,403		\$ 218,933	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (633,359)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 508,750)	918,210		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	94,063		6
7	Other Prepaid Expenses	87,118		7
8	Accounts Receivable (owners or related parties)	5,351		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 471,383	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	350,472		15
16	Equipment, at Historical Cost	259,044		16
17	Accumulated Depreciation (book methods)	(321,237)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 288,279	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 759,662	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,687,678	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	33,320		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,643		31
32	Accrued Real Estate Taxes(Sch.IX-B)			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)	\$ 1,731,641	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DUE TO RELATED PARTY	4,470,271		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,470,271	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,201,912	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (5,442,250)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 759,662	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (5,964,162)	1
2	Restatements (describe):		2
3	ROUNDING	6	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (5,964,156)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	521,906	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	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 521,906	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)	\$ (5,442,250)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number CLARIDGE HEALTHCARE CENTER

0047241

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

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	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,109,842	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,109,842	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,213	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,213	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	332	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 332	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	275	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 275	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,111,662	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	746,806	31
32	Health Care	1,810,815	32
33	General Administration	607,298	33
	B. Capital Expense		
34	Ownership	1,079,431	34
	C. Ancillary Expense		
35	Special Cost Centers	218,933	35
36	Provider Participation Fee	126,473	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,589,756	40
41	Income before Income Taxes (line 30 minus line 40)**	521,906	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 521,906	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.
TAX RETURN PREPARED ON CASH BASIS

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

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	17,922	18,619	465,109	24.98	3
4	Licensed Practical Nurses	3,820	3,856	88,806	23.03	4
5	CNAs & Orderlies	14,470	16,297	188,879	11.59	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,702	1,799	14,842	8.25	9
10	Activity Assistants	4,510	4,542	38,295	8.43	10
11	Social Service Workers	1,228	1,228	18,380	14.97	11
12	Dietician					12
13	Food Service Supervisor	4,855	5,440	74,903	13.77	13
14	Head Cook	1,875	2,032	23,481	11.56	14
15	Cook Helpers/Assistants	9,716	10,181	88,678	8.71	15
16	Dishwashers					16
17	Maintenance Workers	1,051	1,057	24,035	22.74	17
18	Housekeepers	12,371	12,721	107,112	8.42	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator	2,046	2,104	39,968	19.00	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,053	4,153	53,503	12.88	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	219	277	2,499	9.02	31
32	Other Health Care MDS Coordinator	1,955	1,221	14,241	11.66	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	81,793	85,527	\$ 1,242,731 *	\$ 14.53	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 8,367	1-3	35
36	Medical Director	O	36,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	6,336	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	3,081	12-3	45
46	Other(specify) MDS Consultant	S	11,385	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 65,169		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,693	\$ 134,638	10-3	50
51	Licensed Practical Nurses	441	22,050	10-3	51
52	Certified Nurse Assistants/Aides	37,654	677,089	10-3	52
53	TOTAL (lines 50 - 52)	40,788	\$ 833,777		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description		Amount	Description	Amount
ALEXANDER CHI	ASST ADMIN	0	\$ 39,968	Workers' Compensation Insurance		\$ 47,917	IDPH License Fee	\$ 1,990
				Unemployment Compensation Insurance		20,938	Advertising: Employee Recruitment	0
				FICA Taxes		100,069	Health Care Worker Background Check	80
				Employee Health Insurance		0	(Indicate # of checks performed 8)	
				Employee Meals		0	Patient Background Checks	45 450
				Illinois Municipal Retirement Fund (IMRF)*			TRUST/FRANCHISE/CONTRIB/ETC	500
				EMPLOYEE BENEFITS - OTHER		0	MARKETING/ADV/PROMO	11,396
				EMPLOYEE PHYSICAL EXAMS		0	LICENSES/DUES/SUBSCRIPTIONS	1,756
				PENSION/PROFIT SHARING PLANS		0	MGMT CO ALLOC	
TOTAL (agree to Schedule V, line 17, col. 1)				CHICAGO HEAD TAX		0	TRUST/FRANCHISE/CONTRIB/ETC	(500)
(List each licensed administrator separately.)				INSURANCE - EXECUTIVE LIFE		0	Less: Public Relations Expense	(0)
B. Administrative - Other							Non-allowable advertising	(11,396)
Description			Amount	INSURANCE - EXECUTIVE LIFE VI 21		0	Yellow page advertising	(0)
			\$ 0					
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL (agree to Schedule V,		\$ 168,924	TOTAL (agree to Sch. V,	\$ 4,276
(Attach a copy of any management service agreement)				line 22, col.8)			line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
HEALTH DATA SYSTEM	DATA PROCESSING		\$ 7,821			\$	Out-of-State Travel	\$
IVANS	DATA PROCESSING		409					
MEDIFAX EDI LLC	DATA PROCESSING		701					
LTC SOLUTIONS	DATA PROCESSING		1,500				In-State Travel	
KRUPNICK BOKOR KAGDA	ACCOUNTING		39,100					0
ALLSCRIPTS	DATA PROCESSING		3,187					
SALVI SALVI & WIFLER	LEGAL - COLLECTIONS		1,565					
LEGAT ARCHITECTS	MISCELL CONSULTING		4,931				Seminar Expense	
								0
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Entertainment Expense	()
(If total legal fees exceed \$5,000, attach copy of invoices.)							(agree to Sch. V,	
			\$ 59,214				line 24, col. 8)	\$

*** Attach copy of IMRF notifications**

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5	6	7	8	9	10	11	12	13
					Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9							N/A						
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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. _____
- (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? _____
- (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? _____
- (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 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ 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. _____
- (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. \$ 0
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 benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
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: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees