

Facility Name & ID Number ElmBrook HealthCare and Rehabilitation Centre

0044818 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>125</u>	Skilled (SNF)	<u>125</u>	<u>45,625</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>63</u>	Intermediate (ICF)	<u>63</u>	<u>22,995</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>188</u>	TOTALS	<u>188</u>	<u>68,620</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF	<u>5,563</u>	<u>2,452</u>	<u>8,734</u>	<u>16,749</u>	8
9	SNF/PED					9
10	ICF	<u>26,897</u>	<u>3,242</u>	<u>112</u>	<u>30,251</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>32,460</u>	<u>5,694</u>	<u>8,846</u>	<u>47,000</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.49%

D. How many bed-hold days during this year were paid by Public Aid? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 18-Apr-2000

J. Was the facility purchased or leased after January 1, 1978?
YES Date 18-Apr-2000 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 63 and days of care provided 7,892

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 31-Dec-2003 Fiscal Year: 31-Dec-2003

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

STATE OF ILLINOIS

Facility Name & ID Number ElmBrook HealthCare and Rehabilitation Ce # 0044818 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	302,021	26,848	5,097	333,966		333,966		333,966		1
2	Food Purchase		238,055		238,055	(13,522)	224,533	(260)	224,273		2
3	Housekeeping	228,214	48,865		277,079		277,079		277,079		3
4	Laundry	83,608	35,352		118,960		118,960		118,960		4
5	Heat and Other Utilities			240,233	240,233		240,233		240,233		5
6	Maintenance	76,485	72,662	79,640	228,787		228,787	(2,241)	226,546		6
7	Other (specify):*										7
8	TOTAL General Services	690,328	421,782	324,970	1,437,080	(13,522)	1,423,558	(2,501)	1,421,057		8
B. Health Care and Programs											
9	Medical Director			17,900	17,900		17,900		17,900		9
10	Nursing and Medical Records	2,248,951	166,276	7,227	2,422,454		2,422,454		2,422,454		10
10a	Therapy		5,108	8,209	13,317		13,317		13,317		10a
11	Activities	229,966	32,301	6,345	268,612		268,612		268,612		11
12	Social Services	74,140		2,367	76,507		76,507		76,507		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):* *Dental Services**			231	231		231		231		15
16	TOTAL Health Care and Programs	2,553,057	203,685	42,279	2,799,021		2,799,021		2,799,021		16
C. General Administration											
17	Administrative	80,200		276,360	356,560		356,560	(228,556)	128,004		17
18	Directors Fees										18
19	Professional Services			27,459	27,459		27,459	19,306	46,765		19
20	Dues, Fees, Subscriptions & Promotions			94,072	94,072		94,072	(71,612)	22,460		20
21	Clerical & General Office Expenses	302,816	45,404	74,147	422,367		422,367	62,882	485,249		21
22	Employee Benefits & Payroll Taxes			495,026	495,026	13,522	508,548	78,725	587,273		22
23	Inservice Training & Education			415	415		415		415		23
24	Travel and Seminar			6,624	6,624		6,624	10,199	16,823		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			23,344	23,344		23,344		23,344		26
27	Other (specify):* Payroll Taxes (Sch VII)							11,143	11,143		27
28	TOTAL General Administration	383,016	45,404	997,447	1,425,867	13,522	1,439,389	(117,913)	1,321,476		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,626,401	670,871	1,364,696	5,661,968		5,661,968	(120,414)	5,541,554		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.

STATE OF ILLINOIS

Facility Name & ID Number ElmBrook HealthCare and Rehabilitation Centre #0044818 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			93,522	93,522		93,522	38,552	132,074		30
31	Amortization of Pre-Op. & Org.							4,273	4,273		31
32	Interest			40,552	40,552		40,552	490,622	531,174		32
33	Real Estate Taxes			43,200	43,200		43,200		43,200		33
34	Rent-Facility & Grounds			180,000	180,000		180,000	505,494	685,494		34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			357,274	357,274		357,274	1,038,941	1,396,215		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		174,519	267,601	442,120		442,120		442,120		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			102,930	102,930		102,930		102,930		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		174,519	370,531	545,050		545,050		545,050		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,626,401	845,390	2,092,501	6,564,292		6,564,292	918,527	7,482,819		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 ElmBrook HealthCare and Rehabilitation Centre

0044818

Report Period Beginning: 1-Jan-03

Ending: 31-Dec-03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	3,488	30		9
10	Interest and Other Investment Income	(78)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(260)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(44,988)	21		24
25	Fund Raising, Advertising and Promotional	(88,784)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(18,015)	20		28
29	Other-Attach Schedule **Page 5A attached	(6,458)	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (155,095)		\$	30

OHF 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	2	
		Amount	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)	1,073,622	6 & 6A	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,073,622		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 918,527		37

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

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

		1	2	3	4	
		Yes	No	Amount	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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ElmBrook HealthCare and Rehabilitation Centre

ID# 0044818

Report Period Beginning: 1-Jan-03

Ending: 31-Dec-03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Painting & Decorating	\$ (7,750)	6	1
2	Painting & Decorating	1,292	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	(6,458)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ElmBrook HealthCare and Rehabilitation Centre

0044818

Report Period Beginning:

1-Jan-03

Ending:

31-Dec-03

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	(260)	0	0	0	0	0	0	0	0	0	0	(260)	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	(6,458)	4,139	78	0	0	0	0	0	0	0	0	(2,241)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,718)	4,139	78	0	(2,501)	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	Nurse Aide 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	(228,556)	0	0	0	0	0	0	0	0	0	(228,556)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	19,306	0	0	0	0	0	0	0	0	0	19,306	19
20	Fees, Subscriptions & Promotions	(106,799)	35,187	0	0	0	0	0	0	0	0	0	(71,612)	20
21	Clerical & General Office Expenses	(44,988)	107,870	0	0	0	0	0	0	0	0	0	62,882	21
22	Employee Benefits & Payroll Taxes	0	78,725	0	0	0	0	0	0	0	0	0	78,725	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	10,199	0	0	0	0	0	0	0	0	0	10,199	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	11,143	0	0	0	0	0	0	0	0	0	11,143	27
28	TOTAL General Administration	(151,787)	33,874	0	(117,913)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(158,505)	38,013	78	0	(120,414)	29							

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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	17 Officers' Salaries	\$	Lancaster, Ltd.	100.00%	\$ 42,382	\$ 42,382 1
2	V	27 Payroll Taxes-Officers		Lancaster, Ltd.	100.00%	2,238	2,238 2
3	V	17 Management Fee Income	276,360	Lancaster, Ltd.	100.00%		(276,360) 3
4	V	19 Professional Services		Lancaster, Ltd.	100.00%	19,306	19,306 4
5	V	21 Clerical Expenses		Lancaster, Ltd.	100.00%	107,870	107,870 5
6	V	22 Employee Benefits		Lancaster, Ltd.	100.00%	78,725	78,725 6
7	V	24 Education, Travel & Seminars		Lancaster, Ltd.	100.00%	10,199	10,199 7
8	V	17 Administrative Consultant		Lancaster, Ltd.	100.00%	5,422	5,422 8
9	V	20 Licenses, Fees and Marketing		Lancaster, Ltd.	100.00%	35,187	35,187 9
10	V	32 Interest	21,679	Lancaster, Ltd.	100.00%	6,711	(14,968) 10
11	V	30 Depreciation		Lancaster, Ltd.	100.00%	1,101	1,101 11
12	V	6 Maintenance		Lancaster, Ltd.	100.00%	4,139	4,139 12
13	V	27 Payroll Taxes - Clerical		Lancaster, Ltd.	100.00%	8,905	8,905 13
14	Total		\$ 298,039			\$ 322,185	\$ * 24,146 14

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

Facility Name & ID Number ElmBrook HealthCare and Rehabilitation Centre # 0044818 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	34 Rental	\$ 180,000	ElmBrook Associates		\$ 685,494	\$ 505,494
16	V	32 Interest	18,872	ElmBrook Associates		524,540	505,668
17	V	31 Amortization		ElmBrook Associates		4,273	4,273
18	V	30 Depreciation		ElmBrook Associates		33,963	33,963
19	V	6 Repairs & Maintenance		ElmBrook Associates		78	78
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 198,872			\$ 1,248,348	\$ * 1,049,476

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

Facility Name & ID Number ElmBrook HealthCare and Rehabilitation C # 0044818 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

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	Laurence Zung	Executive Officer	Administrative	33.34%	see attached	2	4.17%	Lancaster	\$ 14,221	17-7	1
2	Christopher Vicere	VP-Finance	Administrative	0.00	see attached	5	10.42%	Lancaster	15,420	17-7	2
3	Cheryl Morris	VP-Operation	Administrative	0.00	see attached	5	10.42%	Lancaster	12,741	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 42,382		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 ElmBrook HealthCare and Rehabilitation Centre # 0044818 Report Period Beginning: 1-Jan-03 Ending: 1-Dec-03

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Lancaster, Ltd.
 Street Address 5061 N. Pulaski Road
 City / State / Zip Code Chicago, IL 60630
 Phone Number (773)478.3699
 Fax Number (773)478.1192

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

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	Laurence Zung	Hours Worked	48	7	\$ 341,304	\$ 341,304	2	\$ 14,221	1
2	27	Laurence Zung	Hours Worked	48	7	11,443	0	2	477	2
3	17	Christopher Vicere	Hours Worked	48	7	148,036	148,036	5	15,420	3
4	27	Christopher Vicere	Hours Worked	48	7	8,641	0	5	900	4
5	17	Cheryl Morris	Hours Worked	48	7	122,314	122,314	5	12,741	5
6	27	Cheryl Morris	Hours Worked	48	7	8,268	0	5	861	6
7										7
8										8
9	19	Professional Services	Management Fees	1,974,210	7	137,913	0	276,360	19,306	9
10	21	Clerical Expenses	Management Fees	1,974,210	7	58,516	0	276,360	8,191	10
11	22	Employee Benefits	Management Fees	1,974,210	7	562,384	0	276,360	78,725	11
12	24	Education and Seminars	Management Fees	1,974,210	7	23,865	0	276,360	3,341	12
13	17	Administrative Consultant	Management Fees	1,974,210	7	38,732	38,732	276,360	5,422	13
14	20	Marketing	Management Fees	1,974,210	7	245,986	171,548	276,360	34,434	14
15	32	Interest	Management Fees	1,974,210	7	47,944	0	276,360	6,711	15
16	30	Depreciation	Management Fees	1,974,210	7	7,864	0	276,360	1,101	16
17	20	Licenses and Fees	Management Fees	1,974,210	7	5,379	0	276,360	753	17
18	6	Maintenance	Management Fees	1,974,210	7	29,570	0	276,360	4,139	18
19	24	Travel	Management Fees	1,974,210	7	48,990	0	276,360	6,858	19
20	21	Salaries - Clerical	Management Fees	1,974,210	7	712,068	712,068	276,360	99,679	20
21	27	Payroll Taxes - Clerical	Management Fees	1,974,210	7	63,611	0	276,360	8,905	21
22							0			22
23									0	23
24										24
25	TOTALS					\$ 2,622,828	\$ 1,534,002		\$ 322,185	25

Facility Name & ID Number ElmBrook HealthCare and Rehabilitation Ce # 0044818 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank One		X	Working Capital							6,711	6
7	Harston Investments		X	Working Capital							524,540	7
8												8
9	TOTAL Facility Related						\$	\$			\$ 531,251	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$	\$			\$ 531,251	15

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

* 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 ElmBrook HealthCare and Rehabilitation Centre# 0044818 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

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

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2002 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.)	\$	43,200		2
3.	Under or (over) accrual (line 2 minus line 1).	\$	43,200		3
4.	Real Estate Tax accrual used for 2003 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.	\$	43,200		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1998	_____	8	
		1999	_____	9	
		2000	45,016	10	
		2001	46,676	11	
		2002	49,495	12	
FOR OHF USE ONLY					
13	FROM R. E. TAX STATEMENT FOR 2002	\$			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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ElmBrook HealthCare and Rehabilitation Centre COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0044818

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 2002 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 2002.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>03-26-207-025</u>	<u>Long-Term HealthCare</u>	\$ <u>45,600.70</u>	\$ <u>45,600.70</u>
2. <u>03-26-207-022</u>	<u>Long-Term HealthCare</u>	\$ <u>3,894.68</u>	\$ <u>3,894.68</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>49,495.38</u>	\$ <u>49,495.38</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 & 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 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number ElmBrook HealthCare and Rehabilitation Centre# 0044818 Report Period Beginning:1-Jan-03 Ending:31-Dec-03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

*** None***

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:1. Total Amount Incurred: 21,366 2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 4,273 4. Dates Incurred: 18th April 2000

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				\$	1
2					2
3	TOTALS			\$	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	188			\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Front Sign and Awnings	2001		5,750	499	20	499		1,268
10	General Construction - Phase I	2001		191,999	4,923	20	4,923		10,051
11	Fire Security	2001		9,021	231	20	231		472
12	Electrical	2001		3,045	78	20	78		159
13	Rehab Satellite	2002		86,171	2,209	20	8,617	6,408	9,335
14	General Construction - Phase II	2002		538,782	13,814	20	53,878	40,064	58,368
15	Faux Wood Blinds	2003		3,502	1,775	20	204	(1,571)	204
16	New Roof	2003		36,561	39	20	305	266	305
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
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)		\$ 874,831	\$ 23,568		\$ 68,735	\$ 45,167	\$ 80,162		70

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

Facility Name & ID Number ElmBrook HealthCare and Rehabilitation Centre # 0044818 Report Period Beginning: 1-Jan-03 Ending: 31-Dec-03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 254,256	\$ 60,287	\$ 43,455	\$ (16,832)	10	\$ 87,091	71
72	Current Year Purchases	100,073	39,032	10,386	(28,646)	10	10,386	72
73	Fully Depreciated Assets	9,498	5,699	9,498	3,799		9,498	73
74								74
75	TOTALS	\$ 363,827	\$ 105,018	\$ 63,339	\$ (41,679)		\$ 106,975	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,238,658	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 128,586	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 132,074	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,488	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 187,137	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: York Convalescent Center ** an unrelated entity **

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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ 685,494			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ 685,494			7

10. Effective dates of current rental agreement:
 Beginning 18-Apr-2000
 Ending 17-Apr-2016

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

	Fiscal Year Ending	Annual Rent
12.	<u>12/31/2004</u>	\$ <u>731,464</u>
13.	<u>12/31/2005</u>	\$ <u>741,096</u>
14.	<u>12/31/2006</u>	\$ <u>755,964</u>

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

9. Option to Buy: YES NO Terms: _____ *

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

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

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

C. Vehicle Rental (See instructions.)

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

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

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION: _____</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION: _____</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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	Nurse Aide 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 aides from other facilities.

\$

D. NUMBER OF AIDES 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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Total Cost (Col. 3 + 5 + 6)							
					Units	Cost								
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	113,949	\$		\$	113,949	1		
2	Licensed Speech and Language Development Therapist	39-3	hrs				11,560				11,560	2		
3	Licensed Recreational Therapist		hrs									3		
4	Licensed Physical Therapist	39-3	hrs				140,531				140,531	4		
5	Physician Care		visits									5		
6	Dental Care		visits									6		
7	Work Related Program		hrs									7		
8	Habilitation *Inhalation Therapy	39-3	hrs				1,561				1,561	8		
9	Pharmacy	39-2	# of prescripts						110,585		110,585	9		
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10		
11	Academic Education		hrs									11		
12	Exceptional Care Program											12		
13	Other (specify): ** Medical Supply** ** Specialty Beds**	39-2 39-2							47,665 16,269		47,665 16,269	13		
14	TOTAL			\$		\$	267,601	\$	174,519	\$	442,120	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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number ElmBrook HealthCare and Rehabilitation Centre

0044818

Report Period Beginning: 1-Jan-03

Ending:

31-Dec-03

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 31-Dec-03

(last day of reporting year)

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	\$ 35,307	\$ 35,307	1
2 Cash-Patient Deposits	35,439	35,439	2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,561,193	1,561,193	3
4 Supply Inventory (priced at)			4
5 Short-Term Investments			5
6 Prepaid Insurance	33,465	33,465	6
7 Other Prepaid Expenses			7
8 Accounts Receivable (owners or related parties)	14,261	14,261	8
9 Other(specify):			9
TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,679,665	\$ 1,679,665	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	336,049	874,831	15
16 Equipment, at Historical Cost	281,446	363,828	16
17 Accumulated Depreciation (book methods)	(181,016)	(217,650)	17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs		21,366	19
Accumulated Amortization -			
20 Organization & Pre-Operating Costs		(15,832)	20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):			22
23 Other(specify): **Option Deposit**		1,880,000	23
TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 436,479	\$ 2,906,543	24
TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,116,144	\$ 4,586,208	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 150,961	\$ 150,961	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	35,439	35,439	28
29 Short-Term Notes Payable	2,170,395	608,942	29
30 Accrued Salaries Payable	375,353	375,353	30
31 Accrued Taxes Payable (excluding real estate taxes)	32,763	32,763	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
TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,764,911	\$ 1,203,458	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable		6,316,362	39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43			43
44			44
TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 6,316,362	45
TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,764,911	\$ 7,519,820	46
47 TOTAL EQUITY (page 18, line 24)	\$ (648,767)	\$ (2,933,612)	47
TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,116,144	\$ 4,586,208	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,253,667)	1
2	Restatements (describe):		2
3	Adjustment in Book Depreciation for Taxation	25,840	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,227,827)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	579,060	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)	\$ 579,060	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)	\$ (648,767)	24 *

* This must agree with page 17, line 47.

XVI. STATEMENT OF CHANGES IN EQUITY

		Total after Consolidation	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,489,036)	1
2	Restatements (describe):		2
3	Adjustment in Book Depreciation for Taxation	25,840	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,463,196)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(470,416)	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)	\$ (470,416)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,933,612)	24 *

* This must agree with page 17, line 47, col.2.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,599,301	1
2	Discounts and Allowances for all Levels	(1,524,411)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,074,890	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	872,345	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 872,345	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide 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	139,800	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,905	19
20	Radiology and X-Ray	1,263	20
21	Other Medical Services	42,696	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 195,664	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	78	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 78	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Commissions	375	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 375	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,143,352	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,437,080	31
32	Health Care	2,799,021	32
33	General Administration	1,425,867	33
B. Capital Expense			
34	Ownership	357,274	34
C. Ancillary Expense			
35	Special Cost Centers	442,120	35
36	Provider Participation Fee	102,930	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,564,292	40
41	Income before Income Taxes (line 30 minus line 40)**	579,060	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 579,060	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. **CashBasis 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.

****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	1,981	2,166	\$ 82,385	\$ 38.04	1
2	Assistant Director of Nursing	2,071	2,199	72,650	33.04	2
3	Registered Nurses	28,636	29,834	749,562	25.12	3
4	Licensed Practical Nurses	7,809	8,697	177,091	20.36	4
5	Nurse Aides & Orderlies	95,987	101,845	1,138,343	11.18	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,384	1,655	29,395	17.76	9
10	Activity Assistants	18,557	19,748	200,571	10.16	10
11	Social Service Workers	4,420	4,932	74,140	15.03	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	29,536	31,610	302,021	9.55	15
16	Dishwashers					16
17	Maintenance Workers	4,654	5,126	76,485	14.92	17
18	Housekeepers	24,300	26,434	228,214	8.63	18
19	Laundry	8,876	9,593	83,608	8.72	19
20	Administrator	2,081	2,178	80,200	36.82	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,399	20,092	302,816	15.07	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	2,109	2,216	28,920	13.05	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	250,800	268,325	\$ 3,626,401 *	\$ 13.51	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	151	\$ 5,097	1-3	35
36	Medical Director	325	17,900	9-3	36
37	Medical Records Consultant	102	4,128	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	150	2,256	10-3	39
40	Physical Therapy Consultant	233	8,209	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	209	6,345	11-3	44
45	Social Service Consultant	78	2,367	12-3	45
46	Other(specify) **V.A. Doctor**	21	843	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,269	\$ 47,145		49

C. CONTRACT NURSES

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

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	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	Painting & Decorating	5/2003	\$ 5,700	3	\$	\$	\$ 950	\$ 1,900	\$ 1,900	\$ 950	\$	\$
2	Painting & Decorating	6/2003	2,050	3			342	683	683	342		
3												
4												
5												
6												
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17												
18												
19												
20	TOTALS		\$ 7,750		\$	\$	\$ 1,292	\$ 2,583	\$ 2,583	\$ 1,292	\$	\$

Facility Name & ID Number ElmBrook HealthCare and Rehabilitation Centre# 0044818

Report Period Beginning:

1-Jan-03

Ending:

31-Dec-03

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Council on Long Term Care-\$8,206
- (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? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 23,930 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 102,930
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 of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 13,522 Has any meal income been offset against related costs? _____ 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. \$ 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: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (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 \$2500, 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.