



Facility Name & ID Number DEERBROOK CARE CENTRE

# 0040741 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	214	Skilled (SNF)	214	78,110	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	214	TOTALS	214	78,110	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	8,215	1,309	13,057	22,581	8
9	SNF/PED					9
10	ICF	33,622	5,358	177	39,157	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,837	6,667	13,234	61,738	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.04%

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 04/01/94

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 04/01/94 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 214 and days of care provided 8,171

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number **DEERBROOK CARE CENTRE** # **0040741** Report Period Beginning: **01/01/2006** Ending: **12/31/2006**

**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
	<b>A. General Services</b>										
1	Dietary	286,972	21,142	18,947	327,061		327,061	3,255	330,316		1
2	Food Purchase		217,952		217,952	0	217,952	(1,568)	216,384		2
3	Housekeeping	162,956	29,718	0	192,674		192,674	(7,240)	185,434		3
4	Laundry	72,211	23,464	371	96,046	0	96,046	(1,266)	94,780		4
5	Heat and Other Utilities			170,672	170,672		170,672	0	170,672		5
6	Maintenance	98,381	31,030	24,363	153,774		153,774	1,524	155,298		6
7	Other (specify):*			15,387	15,387		15,387	0	15,387		7
8	<b>TOTAL General Services</b>	<b>620,520</b>	<b>323,306</b>	<b>229,740</b>	<b>1,173,566</b>	<b>0</b>	<b>1,173,566</b>	<b>(5,295)</b>	<b>1,168,271</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director	0		13,600	13,600		13,600	0	13,600		9
10	Nursing and Medical Records	2,793,985	216,250	143,212	3,153,447		3,153,447	(101,325)	3,052,122		10
10a	Therapy	0		0	0		0	0	0		10a
11	Activities	173,354	10,059	0	183,413		183,413	(74)	183,339		11
12	Social Services	0		0	0		0	0	0		12
13	CNA Training			0	0		0	0	0		13
14	Program Transportation			0	0		0	0	0		14
15	Other (specify):*			0	0		0	0	0		15
16	<b>TOTAL Health Care and Programs</b>	<b>2,967,339</b>	<b>226,309</b>	<b>156,812</b>	<b>3,350,460</b>	<b>0</b>	<b>3,350,460</b>	<b>(101,399)</b>	<b>3,249,061</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	185,725		806,180	991,905		991,905	(795,176)	196,729		17
18	Directors Fees			0	0		0	0	0		18
19	Professional Services			423,535	423,535		423,535	(241,945)	181,590		19
20	Dues, Fees, Subscriptions & Promotions			203,195	203,195		203,195	(185,402)	17,793		20
21	Clerical & General Office Expenses	407,498	32,727	48,135	488,360		488,360	184,023	672,383		21
22	Employee Benefits & Payroll Taxes			707,715	707,715	0	707,715	0	707,715		22
23	Inservice Training & Education			6,081	6,081		6,081	0	6,081		23
24	Travel and Seminar			765	765		765	11,518	12,283		24
25	Other Admin. Staff Transportation			3,024	3,024		3,024	0	3,024		25
26	Insurance-Prop.Liab.Malpractice			243,446	243,446		243,446	6,484	249,930		26
27	Other (specify):*			72,000	72,000		72,000	(72,000)	0		27
28	<b>TOTAL General Administration</b>	<b>593,223</b>	<b>32,727</b>	<b>2,514,076</b>	<b>3,140,026</b>	<b>0</b>	<b>3,140,026</b>	<b>(1,092,498)</b>	<b>2,047,528</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>4,181,082</b>	<b>582,342</b>	<b>2,900,628</b>	<b>7,664,052</b>	<b>0</b>	<b>7,664,052</b>	<b>(1,199,192)</b>	<b>6,464,860</b>		<b>29</b>

\*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
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	14,241
	REPAIRS & MAINTENANCE	4,706
		0
		18,947
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	371
		0
		371
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	42,300
	ELECTRICITY	85,842
	WATER	42,353
	CABLE TV - LOBBY	177
		0
		170,672
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	2,591
	PAINTING & DECORATING	1,539
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	1,953
	ELEVATOR MAINTENANCE & REPAIR	9,377
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,575
	FIRE SERVICE	4,328
		0
		0
		0
		0
		24,363
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	15,387
	SECURITY SERVICE	0
		0
		0
		15,387
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	13,600
		13,600

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	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	1,725
	PHARMACY CONSULTANT XVIII B 39-2	1,926
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	134,871
	ALZHEIMERS XVIII B 46-2	233
	PSYCHOLOGIST XVIII B 47-2	4,457
		143,212
<b>10a</b>	<b>THERAPY</b>	
	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 CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	0
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	806,180
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	25,299
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	398,236
		0
		423,535
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	175,096
	EMPLOYEE WANT ADS XIX F	2,522
	CONTRIBUTIONS VI 20 XIX F	1,300
	DUES & SUBSCRIPTIONS XIX F	8,901
	LICENSES & PERMITS XIX F	2,007
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	4,673
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	6,095
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	140
	PATIENT BACKGROUND CHECKS XIX F	2,461
		203,195
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	4,289
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	982
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	40,567
	MESSENGER SERVICE	2,297
		0
		48,135

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	313,217
	UNEMPLOYMENT COMPENSATION XIX D	67,556
	WORKERS COMPENSATION INSURANC XIX D	99,464
	HOSPITALIZATION INSURANCE XIX D	208,784
	EMPLOYEE BENEFITS - OTHER XIX D	7,868
	EMPLOYEE PHYSICAL EXAMS XIX D	3,173
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	7,653
	CHICAGO HEAD TAX XIX D	0
		0
		707,715
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	6,081
		6,081
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	765
		765
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	3,024
		3,024
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	243,446
		243,446
27	<b>OTHER</b>	
	BAD DEBTS VI 24	72,000
		72,000

GRAND TOTAL COLUMN 3 OTHER

2,900,628

DEERBROOK CARE CENTRE  
 EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)  
 12/31/2006

TOTAL FOOD PURCHASE	217,952	PATIENT MEALS	185214
LESS SALES TAX	(1,568)	ADD EMPLOYEE MEALS	0
	-----		-----
NET FOOD	216,384	TOTAL MEALS/YEAR	185214
TOTAL PATIENT CENSUS	61,738	NET FOOD	216384
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	185214
	-----		
TOTAL PATIENT MEALS	185214	COST PER MEAL	1.17
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY			-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
	-----		=====
TOTAL EMPLOYEE MEALS	0		

Facility Name &amp; ID Number

DEERBROOK CARE CENTRE

#0040741

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## 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	
	<b>D. Ownership</b>											
30	Depreciation			44,275	44,275		44,275	262,368	306,643			30
31	Amortization of Pre-Op. & Org.			0	0		0	0	0			31
32	Interest			1,300	1,300		1,300	161,250	162,550			32
33	Real Estate Taxes			91,068	91,068		91,068	0	91,068			33
34	Rent-Facility & Grounds			792,050	792,050		792,050	(753,934)	38,116			34
35	Rent-Equipment & Vehicles			45,458	45,458		45,458	8,334	53,792			35
36	Other (specify):* <b>STORAGE</b>			2,403	2,403		2,403	23,274	25,677			36
37	<b>TOTAL Ownership</b>			976,554	976,554	0	976,554	(298,708)	677,846			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		456,396	698,476	1,154,872		1,154,872	0	1,154,872			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			117,165	117,165		117,165	0	117,165			42
43	Other (specify):*				0		0	0	0			43
44	<b>TOTAL Special Cost Centers</b>	0	456,396	815,641	1,272,037	0	1,272,037	0	1,272,037			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,181,082	1,038,738	4,692,823	9,912,643	0	9,912,643	(1,497,900)	8,414,743			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.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>OHF USE ONLY</b>	
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	28,055	30		9
10	Interest and Other Investment Income	(122,272)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,568)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(982)	21		18
19	Entertainment	0	20		19
20	Contributions	(7,395)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(8,195)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(72,000)	27		24
25	Fund Raising, Advertising and Promotional	(175,096)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,673)	20		28
29	Other-Attach Schedule	(25,012)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (389,138)		\$ 0	30

<b>BHF USE ONLY</b>					
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	
		<b>Amount</b>	<b>Reference</b>	
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)	(1,108,762)	PG 6-6D	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (1,108,762)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,497,900)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

## DEERBROOK CARE CENTRE

ID# 0040741

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 557	6	1
2	VACATION ACCRUAL	3,255	1	2
3	VACATION ACCRUAL	(7,240)	3	3
4	VACATION ACCRUAL	(1,266)	4	4
5	VACATION ACCRUAL	967	6	5
6	VACATION ACCRUAL	(26,661)	10	6
7	VACATION ACCRUAL	(74)	11	7
8	VACATION ACCRUAL	10,263	17	8
9	VACATION ACCRUAL	2,908	21	9
10	MEDICARE A CONSULTANT	(2,000)	19	10
11	MEDICARE B BILLING	(1,700)	19	11
12	MEDICARE A BILLING	(121)	19	12
13	MARKETING CONSULTANT	(3,900)	19	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	<b>Total</b>	(25,012)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number DEERBROOK CARE CENTRE

# 0040741

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## 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	3,255	0	0	0	0	0	0	0	0	0	0	3,255	1
2	Food Purchase	(1,568)	0	0	0	0	0	0	0	0	0	0	(1,568)	2
3	Housekeeping	(7,240)	0	0	0	0	0	0	0	0	0	0	(7,240)	3
4	Laundry	(1,266)	0	0	0	0	0	0	0	0	0	0	(1,266)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	1,524	0	0	0	0	0	0	0	0	0	0	1,524	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(5,295)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(5,295)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(26,661)	0	0	(74,664)	0	0	0	0	0	0	0	(101,325)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(74)	0	0	0	0	0	0	0	0	0	0	(74)	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	<b>TOTAL Health Care and Programs</b>	<b>(26,735)</b>	<b>0</b>	<b>0</b>	<b>(74,664)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(101,399)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	10,263	0	(604,635)	0	741	(201,545)	0	0	0	0	0	(795,176)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(15,916)	0	74,946	735	(301,710)	0	0	0	0	0	0	(241,945)	19
20	Fees, Subscriptions & Promotions	(187,164)	0	516	666	580	0	0	0	0	0	0	(185,402)	20
21	Clerical & General Office Expenses	1,926	0	2,534	4,351	175,212	0	0	0	0	0	0	184,023	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	3,379	4,030	4,109	0	0	0	0	0	0	11,518	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	2,903	2,034	1,547	0	0	0	0	0	0	6,484	26
27	Other (specify):*	(72,000)	0	0	0	0	0	0	0	0	0	0	(72,000)	27
28	<b>TOTAL General Administration</b>	<b>(262,891)</b>	<b>0</b>	<b>(520,357)</b>	<b>11,816</b>	<b>(119,521)</b>	<b>(201,545)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,092,498)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(294,921)</b>	<b>0</b>	<b>(520,357)</b>	<b>(62,848)</b>	<b>(119,521)</b>	<b>(201,545)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,199,192)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number DEERBROOK CARE CENTRE# 0040741

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	28,055	230,200	472	217	3,424	0	0	0	0	0	0	262,368	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(122,272)	283,522	0	0	0	0	0	0	0	0	0	161,250	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(792,050)	0	1,789	36,327	0	0	0	0	0	0	(753,934)	34
35	Rent-Equipment & Vehicles	0	0	3,315	2,483	2,536	0	0	0	0	0	0	8,334	35
36	Other (specify):*	0	23,274	0	0	0	0	0	0	0	0	0	23,274	36
37	<b>TOTAL Ownership</b>	<b>(94,217)</b>	<b>(255,054)</b>	<b>3,787</b>	<b>4,489</b>	<b>42,287</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(298,708)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(389,138)</b>	<b>(255,054)</b>	<b>(516,570)</b>	<b>(58,359)</b>	<b>(77,234)</b>	<b>(201,545)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,497,900)</b>	<b>45</b>

**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
SEE ATTACHED LIST OF OWNERS		SEE ATTACHED LIST OF RELATED NURSING HOMES		DEERBROOK NUSING CENTRE	MORTON GROVE	REAL ESTATE
				SEE ATTACHED LIST OF OTHER RELATED ENTITIES		

**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	\$ 792,050	DEERBROOK NURSING CENTRE		\$	(792,050)	1
2	V	36 MORTGAGE INSURANCE		" "		23,274	23,274	2
3	V	30 DEPRECIATION - BLDG IMP		" "		229,771	229,771	3
4	V	30 DEPRECIATION - EQPT & FN		" "		429	429	4
5	V	32 AMORTIZATION-MTG COST		" "		1,256	1,256	5
6	V	32 MORTGAGE INTEREST		" "		251,480	251,480	6
7	V	32 INTEREST-OTHER		" "		30,786	30,786	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 792,050			\$ 536,996	\$ * (255,054)	14

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

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	19 PROFESSIONAL FEES	\$	WITTINGHAM MANAGEMENT ASSOCIATES, LLC		\$ 74,946	\$ 74,946
16	V	20 DUES & SUBSCRIPTIONS		"		516	516
17	V	21 CLERICAL		"		2,534	2,534
18	V	24 TRAVEL		"		3,379	3,379
19	V	26 INSURANCE		"		2,903	2,903
20	V	35 RENT-EQPT & VEH		"		3,315	3,315
21	V	17 ADMINISTRATIVE	604,635	"			(604,635)
22	V	30 DEPRECIATION		"		472	472
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		\$ 604,635			\$ 88,065	\$ * (516,570)

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

**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	10 NURSING	\$ 123,431	CARLYLE NURSING ASSOCIATES, LLC		\$ 48,767	\$ (74,664)
16	V	19 PROFESSIONAL FEES		" "		735	735
17	V	20 DUES & SUBSCRIPTIONS		" "		666	666
18	V	21 CLERICAL		" "		4,351	4,351
19	V	24 TRAVEL		" "		4,030	4,030
20	V	26 INSURANCE		" "		2,034	2,034
21	V	30 DEPRECIATION		" "		217	217
22	V	34 RENT		" "		1,789	1,789
23	V	35 RENT - EQPT & VEH		" "		2,483	2,483
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		\$ 123,431			\$ 65,072	\$ * (58,359)

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

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	19 PROFESSIONAL FEES	\$ 304,587	THE KENSINGTON GROUP, LLC		\$ 2,877	\$ (301,710)
16	V	20 DUES & SUBSCRIPTIONS		" "		580	580
17	V	21 CLERICAL		" "		175,212	175,212
18	V	24 TRAVEL		" "		4,109	4,109
19	V	26 INSURANCE		" "		1,547	1,547
20	V	30 DEPRECIATION		" "		3,424	3,424
21	V	34 RENT		" "		36,327	36,327
22	V	35 RENT - EQPT & VEH		" "		2,536	2,536
23	V	17 ADMINISTRATIVE		" "		741	741
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		\$ 304,587			\$ 227,353	\$ * (77,234)

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

**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	17 ADMINISTRATIVE	\$ 201,545	CHESTERFIELD, LLC		\$	\$ (201,545)
16	V						
17	V						
18	V						
19	V						
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	<b>Total</b>		\$ 201,545			\$ 0	\$ * (201,545)

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

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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 **DEERBROOK CARE CENTRE**

# **0040741** Report Period Beginning: **01/01/2006**

Ending: **2/31/2006**

**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 WITTINGHAM MANAGEMENT ASSOC. LLC  
 Street Address 8140 RIVER DRIVE  
 City / State / Zip Code MORTON GROVE, IL 60053  
 Phone Number ( 847) 583-0100  
 Fax Number ( 847) 583-8873

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	19	PROFESSIONAL FEES	PATIENT DAYS	345,796	7	\$ 419,864	\$ 61,738	\$ 74,945	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	345,796	7	2,888	61,738	516	2
3	21	CLERICAL	PATIENT DAYS	345,796	7	14,195	61,738	2,534	3
4	24	TRAVEL	PATIENT DAYS	345,796	7	18,932	61,738	3,379	4
5	26	INSURANCE	PATIENT DAYS	345,796	7	16,262	61,738	2,903	5
6	35	RENT - EQPT & VEH	PATIENT DAYS	345,796	7	18,569	61,738	3,315	6
7	30	DEPRECIATION	PATIENT DAYS	345,796	7	2,647	61,738	473	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					\$ 493,357	\$	\$ 88,065	25

Facility Name & ID Number **DEERBROOK CARE CENTRE**

# **0040741** Report Period Beginning: **01/01/2006**

Ending: **2/31/2006**

**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

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

Name of Related Organization CARLYLE NURSING ASSOC. LLC  
 Street Address 8140 RIVER DRIVE  
 City / State / Zip Code MORTON GROVE, IL 60053  
 Phone Number ( 847) 583-0100  
 Fax Number ( 847) 583-8873

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	10	NURSING	DIRECT HOURS	1	\$ 48,767	\$ 48,767	1	\$ 48,767	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	522,604	9	6,221	61,738	735	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	522,604	9	5,639	61,738	666	3
4	21	CLERICAL	PATIENT DAYS	522,604	9	36,838	61,738	4,351	4
5	24	TRAVEL	PATIENT DAYS	522,604	9	34,123	61,738	4,030	5
6	26	INSURANCE	PATIENT DAYS	522,604	9	17,224	61,738	2,034	6
7	30	DEPRECIATION	PATIENT DAYS	522,604	9	1,834	61,738	217	7
8	34	RENT	PATIENT DAYS	522,604	9	15,145	61,738	1,789	8
9	35	RENT - EQPT & VEH	PATIENT DAYS	522,604	9	21,023	61,738	2,483	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				\$ 186,814	\$ 48,767		\$ 65,072	25

Facility Name & ID Number **DEERBROOK CARE CENTRE**

# **0040741** Report Period Beginning: **01/01/2006**

Ending: **2/31/2006**

**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

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

Name of Related Organization THE KENSINGTON GROUP, LLC  
 Street Address 8140 RIVER DRIVE  
 City / State / Zip Code MORTON GROVE, IL 60053  
 Phone Number ( 847) 583-0100  
 Fax Number ( 847) 583-8873

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	19	PROFESSIONAL FEES	PATIENT DAYS	522,604	11	\$ 24,352	\$ 61,738	\$ 2,877	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	522,604	11	4,910	61,738	580	2
3	21	CLERICAL	PATIENT DAYS	522,604	11	162,920	61,738	19,247	3
4	24	TRAVEL	PATIENT DAYS	522,604	11	34,777	61,738	4,109	4
5	26	INSURANCE	PATIENT DAYS	522,604	11	13,097	61,738	1,547	5
6	30	DEPRECIATION	PATIENT DAYS	522,604	11	28,982	61,738	3,424	6
7	34	RENT	PATIENT DAYS	522,604	11	307,494	61,738	36,327	7
8	35	RENT - EQPT VEH	PATIENT DAYS	522,604	11	21,468	61,738	2,536	8
9	17	ADMINISTRATIVE	DIRECT HOURS	1	1	741	741	741	9
10	21	CLERICAL	DIRECT HOURS	1	1	155,965	155,965	155,965	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					\$ 754,706	\$ 156,706	\$ 227,353	25

Facility Name & ID Number

DEERBROOK CARE CENTRE

# 0040741

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

**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		3	4	5	6		7	8	9	10						
		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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	RELATED PARTY - DEERBROOK NURSING CENTRE						\$	\$			\$	1						
2	GMAC		X	MORTGAGE	\$61,407.35	12/03	4,775,900	4,630,551	12/38	5.4000	251,480	2						
3	GMAC		X	LOAN COST	AMORT - 35 YEARS		43,959	40,132			1,256	3						
4												4						
5												5						
<b>Working Capital</b>																		
6	LETTER OF CREDIT FEE		X								1,300	6						
7	RELATED PARTY	X		WORKING CAPITAL	DEMAND	DEMAND	233,532	340,980	VARIES	VARIES	30,786	7						
8												8						
9	TOTAL Facility Related				\$61,407.35		\$ 5,053,391	\$ 5,011,663			\$ 284,822	9						
<b>B. Non-Facility Related*</b>																		
10	IRS, IDR, ETC		X	LATE FEES								10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0	14						
15	TOTALS (line 9+line14)						\$ 5,053,391	\$ 5,011,663			\$ 284,822	15						

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

**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 2005 report.	\$	<b>92,424</b>	<b>1</b>
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.)	\$	<b>91,618</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>(806)</b>	<b>3</b>
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>93,444</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		<b>5</b>
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. <b>TOTAL REFUND \$ <u>1,570</u> For <u>2001</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$	<b>(1,570)</b>	<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>91,068</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	<b>2001</b>	<b>82,957</b>	<b>8</b>
	<b>2002</b>	<b>88,752</b>	<b>9</b>
	<b>2003</b>	<b>88,433</b>	<b>10</b>
	<b>2004</b>	<b>91,416</b>	<b>11</b>
	<b>2005</b>	<b>91,618</b>	<b>12</b>

<b>FOR BHF USE ONLY</b>			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2005	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL**

**THE PAYMENT ON LINE 2 APPLIES TO THE 2005 TAX BILL.**

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- 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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 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 Bureau of Health Finance at (217) 782-1630.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME DEERBROOK CARE CENTRE COUNTY WILL

FACILITY IDPH LICENSE NUMBER 0040741

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 2005 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 2005.

(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>30-07-07-401-034-0000</u>	<u>NURSING HOME</u>	\$ <u>91,618.14</u>	\$ <u>91,618.14</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>91,618.14</u>	\$ <u>91,618.14</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 original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number DEERBROOK CARE CENTRE

# 0040741

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 55,380 B. General Construction Type: Exterior BRICK Frame \_\_\_\_\_ Number of Stories 2

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>NURSING HOME</u>	<u>105,000</u>		\$ <u>247,500</u>	<u>1</u>
2	<u>754 BASIS ADJ</u>	<u>0</u>		<u>13,220</u>	<u>2</u>
3	<b>TOTALS</b>	<b>105,000</b>		\$ <b>260,720</b>	<b>3</b>

Facility Name &amp; ID Number DEERBROOK CARE CENTRE

# 0040741

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

**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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	214		1975	\$ 1,849,704	\$ 29,750	35	\$ 52,849	\$ 23,099	\$ 1,650,454	4
5			1980	168,687	0	20			168,687	5
6	754 ADJ		1992	125,584	4,567	27.5	4,567		66,028	6
7	754 ADJ		2001	29,192	1,062	27.5	1,062		6,372	7
8										8
	<b>Improvement Type**</b>									
9	***** RELATED PARTY - DEERBROOK NURSING CENTRE *****									
10	IMPROVEMENTS		1984	33,823	0	20			33,823	10
11	IMPROVEMENTS		1986	21,535	0	20	534	534	21,535	11
12	IMPROVEMENTS		1987	78,860	2,868	20	3,943	1,075	77,334	12
13	IMPROVEMENTS		1988	48,614	1,768	31.5	1,544	(224)	28,220	13
14	IMPROVEMENTS		1989	60,430	2,197	31.5	1,919	(278)	34,363	14
15	IMPROVEMENTS		1990	30,485	1,108	31.5	967	(141)	15,611	15
16	IMPROVEMENTS		1991	53,134	1,931	31.5	1,688	(243)	26,032	16
17	IMPROVEMENTS		1992	117,363	4,267	31.5	3,725	(542)	53,389	17
18	IMPROVEMENTS		1993	29,335	1,067	39	752	(315)	12,539	18
19	IMPROVEMENTS		1993	29,864	1,085	27.5	1,085		10,863	19
20	IMPROVEMENTS		1994	37,711	1,371	27.5	1,371		16,892	20
21	VINYL SLIDER UNITS		1995	3,070	112	27.5	112		1,283	21
22	DOORS		1995	2,564	93	27.5	93		1,066	22
23	ROOF		1996	24,069	875	27.5	875		9,224	23
24	OUR TOWN		1996	74,400	2,705	27.5	2,705		27,163	24
25	ROOF/REMODEL KITCHEN/DUMPSTER/FLOORS		1997	440,180	16,005	27.5	16,005		150,458	25
26	ALZHEIMERS WING CONSTRUCTION		1997	1,590,575	57,833	27.5	57,833		539,218	26
27	OUR TOWN		1998	21,500	782	27.5	782		7,005	27
28	ALZHEIMERS WING CONSTRUCTION - FINAL DRAW		1998	17,009	618	27.5	618		5,537	28
29	DINING ROOM FLOOR - TILES		1998	30,000	1,091	27.5	1,091		9,774	29
30	DOOR ALARM SYSTEMS		1998	24,760	900	27.5	900		8,063	30
31	SPRINGKLERS		1998	3,500	127	27.5	127		1,138	31
32	DINING ROOM - WALLPAPER/TILE BASE		1998	14,900	542	27.5	542		4,810	32
33	RENOVATE 2 ROOMS/REPLACE ELEVATOR FLOORS		1998	9,400	342	27.5	342		3,007	33
34	REMODELING OF ELEVATOR - LOBBY		1998	7,050	256	27.5	256		2,230	34
35	LANDSCAPING		1998	2,815	102	27.5	102		889	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.

Facility Name &amp; ID Number DEERBROOK CARE CENTRE

# 0040741

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

## 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	ROOF TOP PTAC UNITS	1998	\$ 3,508	\$ 128	27.5	\$ 128	\$	\$ 1,114	37
38	DINING & RESIDENT ROOM FLOORS	1998	15,268	555	27.5	555		4,787	38
39	HOT WATER TANK	1998	1,780	65	27.5	65		560	39
40	REMODELING - SHOWER ROOM	1998	3,830	139	27.5	139		1,164	40
41	ASPHALT PARKING LOT & SPPED BUMPS	1998	17,156	624	27.5	624		5,122	41
42	WALLCOVERING / WINDOW TRMTS/TILES	1998	18,635	678	27.5	678		5,565	42
43	REMODELING - RESIDENT ROOMS	1998	37,050	1,347	27.5	1,347		10,831	43
44	WINDOW TREATMENTS/REMODEL RMS	1999	18,066	657	27.5	657		5,229	44
45	FIRE ALAMS & HVAC/CEILING / HALLS/CALL LIGHTS	1999	25,000	909	27.5	909		7,159	45
46	REPAIR & REMODEL HALLWAY/DOOR MONITOR SYS	1999	23,425	852	27.5	852		6,638	46
47	REMODEL ROOMS/DOOR MONITOR SYS	1999	45,989	1,672	27.5	1,672		12,889	47
48	REMODEL RMS/LANDSCAPING	1999	53,572	1,948	27.5	1,948		14,854	48
49	WALLCOVERING/WINDOW TRMTS/TILES	1999	6,950	253	27.5	253		1,908	49
50	REMODELING RMS	1999	16,205	589	27.5	589		4,393	50
51	WALLCOVERING/FLOOR TILES/HANDRAILES	1999	28,464	1,035	27.5	1,035		7,633	51
52	REMODELING RMS	1999	47,115	1,713	27.5	1,713		12,491	52
53	NURSE STATION/ELEVATOR DOOR	1999	18,030	656	27.5	656		4,729	53
54	REMODELING ROOMS/WINDOW TRMTS	1999	170,712	6,207	27.5	6,207		43,708	54
55	FIRE DAMPERS	2000	4,950	180	27.5	180		1,253	55
56	REMODELING - WASHROOMS/MEDICAL & REC.RM	2000	35,550	1,293	27.5	1,293		8,781	56
57	FENCES	2000	3,557	129	27.5	129		866	57
58	WALLCOVERING/WINDOW TRMT- RES& DINING RMS	2000	69,939	2,543	27.5	2,543		16,636	58
59	FIREWALL/RESIDENT ROOM CEILINGS/TUCKPOINTING	2000	85,160	3,096	27.5	3,096		20,254	59
60	MAGNETIC DOOR/STEAMER	2000	16,334	451	27.5	451		3,028	60
61	HANDRAILS	2000	8,101	295	27.5	295		1,905	61
62	REMODELING - NURSE STATION/CORRIDOR/DINING RM	2000	126,731	4,608	27.5	4,608		29,761	62
63	PTAC UNITS	2000	3,550	129	27.5	129		833	63
64	CONCRETE PAVING	2000	11,700	425	27.5	425		2,745	64
65	IRRIGATION SYSTEM & ROOM PLATES	2000	10,425	379	27.5	379		2,416	65
66	DESIGN & BUILD ENABLING GARDEN	2000	19,832	1,323	15	1,323		8,598	66
67	CARPETING / WINDOW TREATMENT	2000	14,549	529	27.5	529		3,328	67
68	PTAC UNITS	2000	3,550	129	27.5	129		812	68
69	REMODELING - BREAK ROOM, MEDICATION RM	2000	39,886	1,450	27.5	1,450		9,123	69
70	TOTAL (lines 4 thru 69)		\$ 5,984,682	\$ 172,410		\$ 195,375	\$ 22,965	\$ 3,254,120	70

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

Facility Name &amp; ID Number DEERBROOK CARE CENTRE

# 0040741

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

## 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	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 5,984,682	\$ 172,410		\$ 195,375	\$ 22,965	\$ 3,254,120	1
2	SIDEWALK	2000	2,240	81	27.5	81		503	2
3	REMODELING - RESIDENT RMS, LOBBY, MAILROOM	2000	60,826	2,212	27.5	2,212		13,733	3
4	PTAC UNITS	2000	4,644	169	27.5	169		1,049	4
5	WOOD BLINDS FOR OFFICES	2001	3,538	129	27.5	129		768	5
6	CUBICLES	2001	8,332	303	27.5	303		1,805	6
7	REMODEL- ALL 2ND FLOOR RESIDENT ROOMS	2001	370,353	13,466	27.5	13,466		80,237	7
8	VERTICAL BLINDS FOR 2ND FLOOR ROOMS	2001	3,847	140	27.5	140		834	8
9	CARPETING FIRST FLOOR OFFIES/PLUMBING	2001	8,850	322	27.5	322		1,865	9
10	DROP & CHANGE SPRINKLER HEADS IN CORRIDOR	2001	5,097	185	27.5	185		1,056	10
11	REPAIR CEILING ON FIRST FLOOR	2001	25,000	909	27.5	909		5,189	11
12	REPAIR CORRIDOR IN LAUNDRY AREA	2001	10,000	364	27.5	364		2,017	12
13	TEN TON COMPRESSOR FOR KITCHEN UNIT	2001	4,441	161	27.5	161		852	13
14	INSTALL TILE FLOORING IN SERVICE HALLWAY	2002	11,300	411	27.5	411		2,038	14
15	INSTALL ELECTRICAL OUTLETS IN RMS 101 TO 110	2002	8,000	291	27.5	291		1,322	15
16	INTALL PIPE RUN FR. ELECTRICAL CLOSET TO RM 104	2002	1,186	43	27.5	43		195	16
17	FRIEDRICH 11700 BTU PTAC UNITS-2	2002	1,337	49	27.5	49		222	17
18	AMANA - PTAC 12000 BTU HEAT & 11700 PTAC UNIT	2002	1,379	50	27.5	50		223	18
19	REPLACE FIRE PANEL	2003	4,500	164	27.5	164		595	19
20	2 CANVAS AWNINGS	2003	1,650	110	15	110		344	20
21	RESTRIP AND ASPHALT SEAL PARKIGN LOT	2003	6,535	436	15	436		1,362	21
22	INSTALLATOIN OF 4 BATHRM WATER SHUT OFF VALVES	2004	2,360	86	27.5	86		254	22
23	WIRING AND INSTALLATON OF TV'S IN RES. ROOMS	2004	20,700	753	27.5	753		1,977	23
24	CONCRETE WORK DONE TO B WIND SIDE WALK	2004	5,540	201	27.5	201		511	24
25	REPAIR/ REPLACEMENT OF ELECTRICAL LIGHTING CON	2004	7,350	267	27.5	267		679	25
26	INSTALL 80 SOLID CORE, FIRE RATED DOORS	2004	75,115	2,731	27.5	2,731		6,259	26
27	INSTALL NEW ELECTRICAL WIRING & PIPING - 1ST FLR	2004	33,552	1,220	27.5	1,220		2,491	27
28	INSTALLATION OF 20 AMP CIRCUIT IN STORAGE CLOSET	2005	822	30	27.5	30		56	28
29	REMOVED OLD & INSTALLED NEW WATER RECOND.SYS	2005	8,360	304	27.5	304		328	29
30	FIRE SPRINKLER SYSTEM	2005	2,060	75	27.5	75		103	30
31	MORTAR WORK & FIRE CAULK - 1ST FLOOR A,B,C WING								31
32	2ND FLOOR A,B,C WING, SOTRAGE RM & DINING RM	2005	9,740	354	27.5	354		487	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,693,336	\$ 198,426		\$ 221,391	\$ 22,965	\$ 3,383,474	34

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

Facility Name & ID Number DEERBROOK CARE CENTRE

# 0040741

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
1		\$ 6,693,336	\$ 198,426		\$ 221,391	\$ 22,965	\$ 3,383,474	1
2	2006	321,289	8,276	27.5	8,276		8,276	2
3	2006	2,150	68	27.5	68		68	3
4	2006	4,791	36	27.5	36		36	4
5								5
6		ADJ TO SL	22,965			(22,965)		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		\$ 7,021,566	\$ 229,771		\$ 229,771	\$ 0	\$ 3,391,854	34

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

**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	\$ 704,143	\$ 39,712	\$ 71,190	\$ 31,478	3-10 YRS	\$ 449,907	71
72	Current Year Purchases	22,805	4,563	1,140	(3,423)	3-10 YRS	1,140	72
73	Fully Depreciated Assets	9,399			0		9,399	73
74	RELATED PARTY	5,243	4,542	4,542	0	3-10 YRS	3,089	74
75	TOTALS	\$ 741,590	\$ 48,817	\$ 76,872	\$ 28,055		\$ 463,535	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				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	0		\$ 0	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)	\$ 8,023,876	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 278,588	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 306,643	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 28,055	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,855,389	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	<b>TOTAL</b>				\$			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: \$ **37,396** 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	<b>FACILITY USE</b>	<b>99 DODGE DURANGO</b>	\$ <b>295.13</b>	\$ <b>3,394</b>	17
18	<b>ADMINISTRATIVE</b>	<b>2005 CAMRY</b>	<b>389.00</b>	<b>4,668</b>	18
19					19
20					20
21	<b>TOTAL</b>		\$ <b>684.13</b>	\$ <b>8,062</b>	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 Ending Annual Rent

12. \_\_\_\_\_/2007 \$ \_\_\_\_\_

13. \_\_\_\_\_/2008 \$ \_\_\_\_\_

14. \_\_\_\_\_/2009 \$ \_\_\_\_\_

\* 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.)**

<p>1. HAVE YOU TRAINED CNAs 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. <u>CLASSROOM PORTION:</u></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 CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></p>		

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	<b>TOTALS</b>	\$ 0	\$ 0	\$ 0	\$ 0
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$ 0			

**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)	
<b>TOTAL TRAINED</b>	

- (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.)**

	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	\$		\$ 286,057	\$		\$ 286,057	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			109,236			109,236	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			303,183			303,183	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				350,347		350,347	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	X-RAY, LAB, I.V. THERAPY Other (specify): <b>RENTAL</b>	39-2					106,049		106,049	13
14	<b>TOTAL</b>			\$		\$ 698,476	\$ 456,396		\$ 1,154,872	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.

Facility Name &amp; ID Number DEERBROOK CARE CENTRE

# 0040741

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 703,987	\$ 954,409	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 137,116 )	2,743,965	2,743,965	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	1,955	1,955	5
6	Prepaid Insurance	52,732	147,666	6
7	Other Prepaid Expenses	16,320	16,320	7
8	Accounts Receivable (owners or related parties)	4,820	32,820	8
9	Other(specify): <u>ESCROWS</u>		605,506	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,523,779	\$ 4,502,641	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable	1,223,651	882,671	11
12	Long-Term Investments			12
13	Land		247,500	13
14	Buildings, at Historical Cost		1,849,704	14
15	Leasehold Improvements, at Historical Cost		5,013,171	15
16	Equipment, at Historical Cost	728,442	728,442	16
17	Accumulated Depreciation (book methods)	(676,975)	(3,968,647)	17
18	Deferred Charges		136,951	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,275,118	\$ 4,889,792	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,798,897	\$ 9,392,433	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 943,126	\$ 943,126	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	296,792	296,792	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	116,951	116,951	30
31	Accrued Taxes Payable (excluding real estate taxes)	19,515	19,515	31
32	Accrued Real Estate Taxes(Sch.IX-B)		93,444	32
33	Accrued Interest Payable		20,837	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>MANAGEMENT FEES</u>	151,536	151,536	36
37	<u>DUE TO LESSOR</u>	1,013,983	0	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,541,903	\$ 1,642,201	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,630,551	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 0	\$ 4,630,551	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,541,903	\$ 6,272,752	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,256,994	\$ 3,119,681	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,798,897	\$ 9,392,433	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,163,517</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>	<b>REPLACEMENT TAX</b>	(7,996)	<b>4</b>
<b>5</b>	<b>ROUNDING ADJ.</b>	3	<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>2,155,524</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>101,470</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>101,470</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>0</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>2,256,994</b>	<b>24</b> *

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

**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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 9,890,966	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 9,890,966	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 0	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	15	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 15	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	122,272	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 122,272	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>NET VENDING COMMISSIONS</b>	860	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 860	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 10,014,113	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,173,566	31
32	Health Care	3,350,460	32
33	General Administration	3,140,026	33
	<b>B. Capital Expense</b>		
34	Ownership	976,554	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	1,154,872	35
36	Provider Participation Fee	117,165	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 9,912,643	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	101,470	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 101,470	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.

Facility Name & ID Number DEERBROOK CARE CENTRE

# 0040741

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

**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	1,857	2,171	\$ 96,937	\$ 44.65	1
2	Assistant Director of Nursing	1,460	1,519	45,155	29.73	2
3	Registered Nurses	32,300	34,693	1,005,088	28.97	3
4	Licensed Practical Nurses	25,274	26,906	599,386	22.28	4
5	CNAs & Orderlies	92,311	98,520	1,014,481	10.30	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,259	4,691	100,347	21.39	9
10	Activity Assistants	9,692	10,239	73,007	7.13	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	11,718	12,380	170,334	13.76	14
15	Cook Helpers/Assistants	14,702	15,677	116,638	7.44	15
16	Dishwashers					16
17	Maintenance Workers	6,307	7,181	98,381	13.70	17
18	Housekeepers	18,000	19,029	162,956	8.56	18
19	Laundry	9,960	10,580	72,211	6.83	19
20	Administrator	1,871	2,510	135,187	53.86	20
21	Assistant Administrator	1,497	1,804	50,538	28.01	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,433	22,447	407,498	18.15	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,934	2,109	32,938	15.62	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	253,575	272,456	\$ 4,181,082 *	\$ 15.35	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	225	\$ 14,241	1-3	35
36	Medical Director	136	13,600	9-3	36
37	Medical Records Consultant	23	1,725	10-3	37
38	Nurse Consultant	925	134,871	10-3	38
39	Pharmacist Consultant	144	1,926	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant		0	12-3	45
46	Other(specify) <u>ALZHEIMERS</u>	8	233	10-3	46
47	<u>PSYCHOLOGIST</u>	60	4,457	10-3	47
48					48
49	TOTAL (lines 35 - 48)	1,521	\$ 171,053		49

**C. CONTRACT NURSES**

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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
JUDY JUNE	ADMINISTRATOR		\$ 135,187	Workers' Compensation Insurance	\$ 99,464	IDPH License Fee	\$	
KATHY SMITH	ASST ADMIN		29,933	Unemployment Compensation Insurance	67,556	Advertising: Employee Recruitment	2,522	
BENJAMIN FRIEDMAN	ASST ADMIN		16,945	FICA Taxes	313,217	Health Care Worker Background Check	140	
MARIO LONGO	ASST ADMIN		3,660	Employee Health Insurance	208,784	(Indicate # of checks performed <u>14</u> )		
				Employee Meals	0	Patient Background Checks	246	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	7,395	
				EMPLOYEE BENEFITS - OTHER	7,868	MARKETING/ADV/PROMO	179,769	
				EMPLOYEE PHYSICAL EXAMS	3,173	LICENSES/DUES/SUBSCRIPTIONS	10,908	
				PENSION/PROFIT SHARING PLANS	7,653	MGMT CO ALLOC	1,762	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	(7,395)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	( 0 )	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(175,096)	
						Yellow page advertising	(4,673)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 185,725	TOTAL (agree to Schedule V, line 22, col.8)	\$ 707,715	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 17,793	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
WITTINGHAM MANAGEMENT ASSOC, LLC			\$ 604,635			\$	Out-of-State Travel	\$
CHESTERFIELD, LLC			201,545					
							In-State Travel	
							TRAVEL	765
							RELATED PARTY	11,518
							Seminar Expense	
								0
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 806,180	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 12,283
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
SEE SCHEDULE ATTACHED			423,535					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 423,535					

\* 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	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	06/2004	\$ 1,765	3	\$	\$ 294	\$ 588	\$ 588	\$ 295	\$	\$	\$								
2	PAINT/DECORATING	06/2005	3,753	3			626	1,251	1,251	625										
3	PAINT/DECORATING	06/2006	1,539	3				257	513	513	256									
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	<b>TOTALS</b>		\$ 7,057		\$	\$ 294	\$ 1,214	\$ 2,096	\$ 2,059	\$ 1,138	\$ 256	\$								

Facility Name &amp; ID Number DEERBROOK CARE CENTRE

# 0040741

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IL COUNCIL ON LONG TERM CARE - \$12187
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (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. \$ 10,717 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. \$ 117,165  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 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: \_\_\_\_\_ 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