

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044818

Facility Name: Elm Brook Healthcare & Rehabilitation Centre

Address: 127 West Diversey Avenue Elmhurst 60126
 Number City Zip Code

County: DuPage

Telephone Number: (630) 530-5225 **Fax #** (630) 530-7775

HFS ID Number: 36-4351749

Date of Initial License for Current Owners: 18th April 2000

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Christopher Vicere **Telephone Number:** (773) 604-4416

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1-Jan-2006 to 31-Dec-2006 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 29th March 2007
 (Date)

(Type or Print Name) Christopher Vicere

(Title) Vice President - Finance

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) _____

(Firm Name & Address) _____

(Telephone) () Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Elm Brook Healthcare & Rehabilitation Centre# 0044818 Report Period Beginning: 1-Jan-2006 Ending: 31-Dec-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	<u>117</u>	Skilled (SNF)	<u>117</u>	<u>42,705</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>180</u>	TOTALS	<u>180</u>	<u>65,700</u>	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	<u>18,128</u>	<u>2,834</u>	<u>7,458</u>	<u>28,420</u>	8
9	SNF/PED					9
10	ICF	<u>26,031</u>	<u>3,495</u>	<u>51</u>	<u>29,577</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>44,159</u>	<u>6,329</u>	<u>7,509</u>	<u>57,997</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.28%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NoneF. 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 18th April, 2000

J. Was the facility purchased or leased after January 1, 1978?

YES Date 18th April 2000 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 117 and days of care provided 6,902Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 31st Dec 2006 Fiscal Year: 31st Dec 2006

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

Facility Name & ID Number Elm Brook Healthcare & Rehabilitation Cent # 0044818 Report Period Beginning: 1-Jan-2006 Ending: 31-Dec-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	
	A. General Services											
1	Dietary	366,638	53,338	12,497	432,473		432,473		432,473			1
2	Food Purchase		320,589		320,589	(15,500)	305,089	(316)	304,773			2
3	Housekeeping	322,459	62,775		385,234		385,234		385,234			3
4	Laundry	97,952	53,354		151,306		151,306		151,306			4
5	Heat and Other Utilities			303,845	303,845		303,845		303,845			5
6	Maintenance	85,658	66,268	66,693	218,619		218,619	(1,420)	217,199			6
7	Other (specify):*											7
8	TOTAL General Services	872,707	556,324	383,035	1,812,066	(15,500)	1,796,566	(1,736)	1,794,830			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	3,275,582	64,323	73,565	3,413,470		3,413,470		3,413,470			10
10a	Therapy		7,886	3,692	11,578		11,578		11,578			10a
11	Activities	198,086	46,137	8,950	253,173		253,173		253,173			11
12	Social Services	109,079		1,337	110,416		110,416		110,416			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,582,747	118,346	101,944	3,803,037		3,803,037		3,803,037			16
	C. General Administration											
17	Administrative	94,403		287,280	381,683		381,683	(180,979)	200,704			17
18	Directors Fees											18
19	Professional Services			40,278	40,278		40,278	15,505	55,783			19
20	Dues, Fees, Subscriptions & Promotions			44,449	44,449		44,449	(24,779)	19,670			20
21	Clerical & General Office Expenses	182,065	49,389	21,971	253,425		253,425	54,526	307,951			21
22	Employee Benefits & Payroll Taxes			831,633	831,633	15,500	847,133	9,910	857,043			22
23	Inservice Training & Education			17,500	17,500		17,500	2,282	19,782			23
24	Travel and Seminar			5,790	5,790		5,790	3,693	9,483			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			11,497	11,497		11,497		11,497			26
27	Other (specify):* *Payroll Taxes (Sch VII)							19,512	19,512			27
28	TOTAL General Administration	276,468	49,389	1,260,398	1,586,255	15,500	1,601,755	(100,330)	1,501,425			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,731,922	724,059	1,745,377	7,201,358		7,201,358	(102,066)	7,099,292			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (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			66,092	66,092		66,092	372,619	438,711		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			175,591	175,591		175,591	485,577	661,168		32
33	Real Estate Taxes			58,417	58,417		58,417		58,417		33
34	Rent-Facility & Grounds			1,500,000	1,500,000		1,500,000	(1,500,000)			34
35	Rent-Equipment & Vehicles			2,002	2,002		2,002		2,002		35
36	Other (specify):* *Amortization of Goodwill*			195,618	195,618		195,618		195,618		36
37	TOTAL Ownership			1,997,720	1,997,720		1,997,720	(641,804)	1,355,916		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		427,104	720,157	1,147,261		1,147,261		1,147,261		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			98,550	98,550		98,550		98,550		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		427,104	818,707	1,245,811		1,245,811		1,245,811		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,731,922	1,151,163	4,561,804	10,444,889		10,444,889	(743,870)	9,701,019		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	
	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	65,712	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(316)	2		13
14	Non-Care Related Interest	(67,861)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(1,143)	24		19
20	Contributions	(100)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(8,324)	21		24
25	Fund Raising, Advertising and Promotional	(52,711)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,474)	20		28
29	Other-Attach Schedule ** Page 5A attached **	(1,420)	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (68,637)		\$	30

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)	(675,233)	6 & 6A	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (675,233)		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (743,870)		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

BHF USE ONLY						
48		49		50		51
						52

Elm Brook Healthcare & Rehabilitation Centre

ID# 0044818

Report Period Beginning: 1-Jan-2006

Ending: 31-Dec-2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Painting & Decorating (incurred in 2006)	\$ (6,442)	6 1
2	Painting & Decorating (allocated for 2006)	5,022	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	(1,420)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elm Brook Healthcare & Rehabilitation Centre

0044818

Report Period Beginning:

1-Jan-2006

Ending:

31-Dec-2006

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	(316)	0	0	0	0	0	0	0	0	0	0	(316)	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	(1,420)	0	0	0	0	0	0	0	0	0	0	(1,420)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,736)	0	0	0	0	0	0	0	0	0	0	(1,736)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(180,979)	0	0	0	0	0	0	0	0	0	(180,979)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	14,780	725	0	0	0	0	0	0	0	0	15,505	19
20	Fees, Subscriptions & Promotions	(55,285)	30,386	120	0	0	0	0	0	0	0	0	(24,779)	20
21	Clerical & General Office Expenses	(8,324)	62,850	0	0	0	0	0	0	0	0	0	54,526	21
22	Employee Benefits & Payroll Taxes	0	9,910	0	0	0	0	0	0	0	0	0	9,910	22
23	Inservice Training & Education	0	2,282	0	0	0	0	0	0	0	0	0	2,282	23
24	Travel and Seminar	(1,143)	4,836	0	0	0	0	0	0	0	0	0	3,693	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	19,512	0	0	0	0	0	0	0	0	0	19,512	27
28	TOTAL General Administration	(64,752)	(36,423)	845	0	(100,330)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(66,488)	(36,423)	845	0	(102,066)	29							

STATE OF ILLINOIS

Facility Name & ID Number Elm Brook Healthcare & Rehabilitation Centre

0044818

Report Period Beginning:

1-Jan-2006 Ending:

Summary B

31-Dec-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	65,712	700	306,207	0	0	0	0	0	0	0	0	372,619	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(67,861)	(143,898)	697,336	0	0	0	0	0	0	0	0	485,577	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(1,500,000)	0	0	0	0	0	0	0	0	(1,500,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,149)	(143,198)	(496,457)	0	(641,804)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(68,637)	(179,621)	(495,612)	0	(743,870)	45							

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 Management Fee Income	\$ 287,280	Lancaster, Ltd.	100.00%	\$	\$ (287,280) 1
2	V	17 Officers Salary		Lancaster, Ltd.	100.00%	36,999	36,999 2
3	V	19 Professional Services		Lancaster, Ltd.	100.00%	14,780	14,780 3
4	V	21 Clerical Expenses		Lancaster, Ltd.	100.00%	62,850	62,850 4
5	V	22 Employee Benefits		Lancaster, Ltd.	100.00%	9,910	9,910 5
6	V	24 Seminars & Travel		Lancaster, Ltd.	100.00%	4,836	4,836 6
7	V	17 Administrative Consulting		Lancaster, Ltd.	100.00%	69,302	69,302 7
8	V	20 Marketing and Fees		Lancaster, Ltd.	100.00%	29,742	29,742 8
9	V	32 Interest	145,066	Lancaster, Ltd.	100.00%	1,168	(143,898) 9
10	V	30 Depreciation		Lancaster, Ltd.	100.00%	700	700 10
11	V	20 Dues, Fees and Subscriptions		Lancaster, Ltd.	100.00%	644	644 11
12	V	27 Payroll Taxes (Staff & Officers)		Lancaster, Ltd.	100.00%	19,512	19,512 12
13	V	23 Education & Inservice		Lancaster, Ltd.	100.00%	2,282	2,282 13
14	Total		\$ 432,346			\$ 252,725	\$ * (179,621) 14

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

Facility Name & ID Number Elm Brook Healthcare & Rehabilitation Centre # 0044818 Report Period Beginning: 1-Jan-2006 Ending: 31-Dec-2006

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	\$ 1,500,000	Elmbrook Associates		\$	(1,500,000)	15
16	V	32 Interest	38,589	Elmbrook Associates		735,925	697,336	16
17	V	30 Depreciation		Elmbrook Associates		306,207	306,207	17
18	V	20 License & Fees		Elmbrook Associates		120	120	18
19	V	19 Accounting Fees		Elmbrook Associates		725	725	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 1,538,589			\$ 1,042,977	\$ * (495,612)	39

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

Facility Name & ID Number Elm Brook Healthcare & Rehabilitation Cer # 0044818 Report Period Beginning: 1-Jan-2006 Ending: 31-Dec-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	Christopher Vicere	VP-Finance	Administrative		See attached	5	10.42	Lancaster	\$ 18,521	17-7	1
2	Cheryl Morris	VP-Operations	Administrative		See attached	5	10.42	Lancaster	18,478	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 36,999		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 Elm Brook Healthcare & Rehabilitation Centre # 0044818 Report Period Beginning: 1-Jan-2006 Ending: -Dec-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 Lancaster, Ltd.
 Street Address 5061 N. Pulaski Road,
 City / State / Zip Code Chicago, IL 60630
 Phone Number (773) 604-4416
 Fax Number (773) 478-1192

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	17	Christopher Vicere	Hours Worked	48	7	\$ 177,802	\$ 177,802	5	\$ 18,521	1
2	27	Christopher Vicere-payroll tax	Hours Worked	48		9,454		5	985	2
3	17	Cheryl Morris	Hours Worked	48		177,385	177,385	5	18,478	3
4	27	Cheryl Morris-payroll tax	Hours Worked	48		9,436		5	983	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13	19	Professional Services	Management Fees	2,146,620	7	110,443		287,280	14,780	13
14	21	Clerical Expenses	Management Fees	2,146,620	7	469,632	428,989	287,280	62,850	14
15	22	Employee Benefits	Management Fees	2,146,620	7	74,046		287,280	9,910	15
16	24	Seminars & Travel	Management Fees	2,146,620	7	36,138		287,280	4,836	16
17	17	Administrative Consulting	Management Fees	2,146,620	7	517,841	471,840	287,280	69,302	17
18	20	Marketing and Fees	Management Fees	2,146,620	7	222,241	180,200	287,280	29,742	18
19	32	Interest	Management Fees	2,146,620	7	8,729		287,280	1,168	19
20	30	Depreciation	Management Fees	2,146,620	7	5,231		287,280	700	20
21	20	Dues, Fees and Subscriptions	Management Fees	2,146,620	7	4,809		287,280	644	21
22	27	Payroll Taxes	Management Fees	2,146,620	7	131,096		287,280	17,544	22
23	23	Education & Inservice	Management Fees	2,146,620	7	17,054		287,280	2,282	23
24	32	*Direct Interest*								24
25	TOTALS					\$ 1,971,337	\$ 1,436,216		\$ 252,725	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6	JP Morgan Chase Bank		X	Working Capital						1,168	6									
7	Harston Investments		X	Working Capital						660,000	7									
8											8									
9	TOTAL Facility Related									661,168	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related										14									
15	TOTALS (line 9+line14)									661,168	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* 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

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2005 report.		\$ 49,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 52,417	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 3,417	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 55,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 58,417	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2001	46,676	8
	2002	49,495	9
	2003	45,836	10
	2004	47,519	11
	2005	52,417	12
* Accrual for 2006 report is based on 2005 Taxes adjusted for inflation			
FOR BHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2005 \$	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:** 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 Elm Brook Healthcare & 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 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>03-26-207-022</u>	<u>Long-Term Health Care</u>	\$ <u>48,292.36</u>	\$ <u>48,292.36</u>
2. <u>03-26-207-025</u>	<u>Long-Term Health Care</u>	\$ <u>4,124.30</u>	\$ <u>4,124.30</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>52,416.66</u>	\$ <u>52,416.66</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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,800 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 4

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).

*** 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: None 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Care Facility</u>	<u>67,000</u>	<u>2004</u>	<u>\$ 565,000</u>	1
2					2
3	TOTALS	67,000		\$ 565,000	3

Facility Name & ID Number **Elm Brook Healthcare & Rehabilitation Centre**

0044818

Report Period Beginning:

1-Jan-2006 Ending: 31-Dec-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	180		2004		\$ 6,815,732	\$ 174,755	40	\$ 174,763	\$ 8	\$ 458,751	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Front Sign and Awnings		2001	5,750	363	15	363		2,482	9
10		General Construction - Phase I		2001	191,999	4,923	20	4,923		24,820	10
11		Fire Security		2001	9,021	231	20	231		1,165	11
12		Electrical		2001	3,045	78	20	78		393	12
13		Rehab Satellite		2002	86,171	2,209	10	8,617	6,408	35,186	13
14		General Construction - Phase II		2002	538,782	13,814	10	53,878	40,064	220,002	14
15		Faux Wood Blinds		2003	3,502	202	5	700	498	2,304	15
16		New Roof		2003	36,561	937	10	3,656	2,719	11,273	16
17		Upgrade Elevators		2004	34,190	877	20	1,710	833	3,705	17
18		Construction & Design Cost		2004	15,873	407	10	1,588	1,181	4,755	18
19		Elevator Fire Alarm Equipment		2005	9,360	240	10	936	696	1,872	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

*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	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)	\$ 7,749,986	\$ 199,036		\$ 251,443	\$ 52,407	\$ 766,708	70

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

Facility Name & ID Number Elm Brook Healthcare & Rehabilitation Centre # 0044818 Report Period Beginning: 1-Jan-2006 Ending: 31-Dec-2006

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	\$ 945,771	\$ 151,286	\$ 171,555	\$ 20,269	7	\$ 529,444	71
72	Current Year Purchases	105,493	21,099	14,583	(6,516)	7	14,583	72
73	Fully Depreciated Assets	51,928	877	429	(448)	7	51,928	73
74	**Lancaster Allocation**		700	700		7	4,179	74
75	TOTALS	\$ 1,103,192	\$ 173,962	\$ 187,267	\$ 13,305		\$ 600,134	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)	\$ 9,418,178	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 372,998	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 438,710	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 65,712	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,366,842	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: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

YES NO

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

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	\$ _____

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: \$ 2,002 Description: E Cylinder (Oxygen) @\$4 per cylinder per month and @\$2 per half month or part thereof

(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.

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>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	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	\$		\$ 290,060	\$		\$ 290,060	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			71,432			71,432	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			357,788			357,788	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	39-3	hrs			877			877	8
9	Pharmacy	39-2	# of prescripts				136,025		136,025	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 Supplies**	39-2					184,564		184,564	13
	Speciality Beds	39-2					106,515		106,515	13
14	TOTAL			\$		\$ 720,157	\$ 427,104		\$ 1,147,261	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 & ID Number Elm Brook Healthcare & Rehabilitation Centre # 0044818 Report Period Beginning: 1-Jan-2006 Ending: 31-Dec-2006

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 31-Dec-2006 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 350	\$ 5,350	1
2	Cash-Patient Deposits	41,575	41,575	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,963,182	2,963,182	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	57,898	57,898	6
7	Other Prepaid Expenses	61	61	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): **Refundable Deposit**	23,230	23,230	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,086,296	\$ 3,091,296	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		565,000	13
14	Buildings, at Historical Cost		6,815,732	14
15	Leasehold Improvements, at Historical Cost	379,600	934,255	15
16	Equipment, at Historical Cost	455,809	1,103,191	16
17	Accumulated Depreciation (book methods)	(370,924)	(1,350,847)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		21,366	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(21,366)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **Goodwill**)	2,934,268	2,934,268	22
23	Other(specify): **Goodwill Amortization**	(505,346)	(505,346)	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,893,407	\$ 10,496,253	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,979,703	\$ 13,587,549	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 187,681	\$ 187,681	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	41,575	41,575	28
29	Short-Term Notes Payable	4,065,162	3,174,599	29
30	Accrued Salaries Payable	448,471	448,471	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,999	20,999	31
32	Accrued Real Estate Taxes(Sch.IX-B)	55,000	55,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,818,888	\$ 3,928,325	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		8,100,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 8,100,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,818,888	\$ 12,028,325	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,160,815	\$ 1,559,224	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,979,703	\$ 13,587,549	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,678,283)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,678,283)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(660,902)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	3,500,000	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)	\$ 2,839,098	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)	\$ 1,160,815	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	\$ (3,275,485)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,275,485)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(165,291)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	5,000,000	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)	\$ 4,834,709	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)	\$ 1,559,224	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Elm Brook Healthcare & Rehabilitation Centre # 0044818 Report Period Beginning: 1-Jan-2006Ending: 31-Dec-2006**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	\$ 9,566,555	1
2	Discounts and Allowances for all Levels	(1,703,519)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,863,036	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,668,562	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,668,562	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	214,774	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,627	19
20	Radiology and X-Ray	4,930	20
21	Other Medical Services	24,058	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 252,389	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,783,987	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,812,066	31
32	Health Care	3,803,037	32
33	General Administration	1,586,255	33
B. Capital Expense			
34	Ownership	1,997,720	34
C. Ancillary Expense			
35	Special Cost Centers	1,147,261	35
36	Provider Participation Fee	98,550	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,444,889	40
41	Income before Income Taxes (line 30 minus line 40)**	(660,902)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (660,902)	43

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

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

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

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

Facility Name & ID Number Elm Brook Healthcare & Rehabilitation Centre

0044818

Report Period Beginning:

1-Jan-2006

Ending:

31-Dec-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	1,989	2,174	\$ 93,610	\$ 43.06	1
2	Assistant Director of Nursing	1,970	2,174	83,166	38.25	2
3	Registered Nurses	37,704	39,576	1,024,334	25.88	3
4	Licensed Practical Nurses	8,669	9,400	226,386	24.08	4
5	CNAs & Orderlies	148,300	158,221	1,817,779	11.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,866	2,084	29,391	14.10	9
10	Activity Assistants	12,975	13,670	168,695	12.34	10
11	Social Service Workers	7,712	8,246	109,079	13.23	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	36,139	38,405	366,638	9.55	15
16	Dishwashers					16
17	Maintenance Workers	5,526	5,880	85,658	14.57	17
18	Housekeepers	32,377	34,988	322,459	9.22	18
19	Laundry	10,759	11,427	97,952	8.57	19
20	Administrator	1,899	2,086	94,403	45.26	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,392	13,687	182,065	13.30	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	1,944	2,088	30,307	14.51	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	322,221	344,106	\$ 4,731,922 *	\$ 13.75	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	378	\$ 12,497	1-3	35
36	Medical Director	260	14,400	9-3	36
37	Medical Records Consultant	113	4,400	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	150	2,256	10-3	39
40	Physical Therapy Consultant	108	3,692	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	299	8,950	11-3	44
45	Social Service Consultant	45	1,337	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,353	\$ 47,532		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,783	\$ 66,909	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,783	\$ 66,909		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		
Connie L. Sherman	Administrator	N/A	\$ 94,403	Workers' Compensation Insurance	\$ 96,639	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance	79,372	Advertising: Employee Recruitment	2,683		
				FICA Taxes	356,700	Health Care Worker Background Check	5,387		
				Employee Health Insurance	133,306	(Indicate # of checks performed <u>359</u>)			
				Employee Meals	15,500	Patient Background Checks <u>348</u>	5,220		
				Illinois Municipal Retirement Fund (IMRF)*	0	***Licenses and Fees***	2,416		
				Retirement Plan Contributions	10,995	***Dues and Subscriptions***	1,310		
				Misc. Employee Benefits	22,687	***Advertising and Promotions***	25,443		
				Employment Fees	118,550	***Lancaster Allocation***	30,386		
				Holiday Expenses	13,384	***Elmhurst Associates Allocation***	120		
				Lancaster Allocation	9,910	Less: Public Relations Expense	(1,161)		
						Non-allowable advertising	(51,650)		
						Yellow page advertising	(2,474)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 94,403	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)			
				\$ 857,043		\$ 19,670			
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	
Management Fees - Lancaster		\$ 287,280					Out-of-State Travel	\$	
							In-State Travel	1,110	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		\$ 287,280					Seminar Expense	4,680	
C. Professional Services								***Lancaster Allocation***	4,836
Vendor/Payee	Type	Amount					Entertainment Expense	(1,143)	
Frost Ruttenberg and Rothblatt	Accounting	\$ 1,310					(agree to Sch. V, line 24, col. 8)		
Richard Peelo	Accounting	2,250					TOTAL	\$ 9,483	
Personnel Planners	Unemployment Tax Consult.	2,162							
A T & T Internet Services	Data Processing	606							
Health Data Systems, Inc.	Data Processing	7,620							
Accu-med Services, Inc.	Data Processing	3,120							
Stone, Pogrund & Korey	Legal	21,275							
Myers, Miller & Krauskopf	Legal	1,935							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 40,278	TOTAL		\$			

* Attach copy of IMRF notifications

**See instructions.

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

(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
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	Painting & Decorating	2/2004	1,992	3		332	664	664	332				
4	Painting & Decorating	8/2004	1,528	3		255	509	509	255				
5	Painting & Decorating	12/2004	1,968	3		328	656	656	328				
6	Painting & Decorating	3/2005	2,480	3			413	827	827	413			
7	Painting & Decorating	7/2006	6,442	3				1,074	2,147	2,147	1,074		
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 22,160		\$ 1,292	\$ 3,498	\$ 4,825	\$ 5,022	\$ 3,889	\$ 2,560	\$ 1,074	\$	\$

