



Facility Name & ID Number DEERBROOK CARE CENTRE

# 0040741 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	9,311	1,427	16,235	26,973	8
9	SNF/PED					9
10	ICF	34,754	5,326		40,080	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,065	6,753	16,235	67,053	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.84%

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 8,543

Medicare Intermediary WPS (WISCONSIN PHYSICIANS SERVICES)

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number **DEERBROOK CARE CENTRE** # **0040741** Report Period Beginning: **01/01/2007** Ending: **12/31/2007**

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	304,574	23,378	15,415	343,367		343,367	(4,447)	338,920		1
2	Food Purchase		254,097		254,097		254,097	(2,107)	251,990		2
3	Housekeeping	217,737	32,819		250,556		250,556	3,274	253,830		3
4	Laundry	77,361	25,321	2,483	105,165		105,165	2,803	107,968		4
5	Heat and Other Utilities			182,460	182,460		182,460		182,460		5
6	Maintenance	80,840	30,893	26,053	137,786		137,786	150	137,936		6
7	Other (specify):* <b>STORAGE</b>			17,616	17,616		17,616		17,616		7
8	<b>TOTAL General Services</b>	680,512	366,508	244,027	1,291,047		1,291,047	(327)	1,290,720		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			24,800	24,800		24,800		24,800		9
10	Nursing and Medical Records	3,021,349	222,112	154,939	3,398,400		3,398,400	(76,196)	3,322,204		10
10a	Therapy										10a
11	Activities	196,620	13,734		210,354		210,354	(401)	209,953		11
12	Social Services			171	171		171		171		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	3,217,969	235,846	179,910	3,633,725		3,633,725	(76,597)	3,557,128		16
	<b>C. General Administration</b>										
17	Administrative	189,752		895,655	1,085,407		1,085,407	(895,158)	190,249		17
18	Directors Fees										18
19	Professional Services			458,135	458,135		458,135	(249,950)	208,185		19
20	Dues, Fees, Subscriptions & Promotions			144,087	144,087		144,087	(120,069)	24,018		20
21	Clerical & General Office Expenses	453,552	34,678	53,717	541,947		541,947	207,507	749,454		21
22	Employee Benefits & Payroll Taxes			722,471	722,471		722,471		722,471		22
23	Inservice Training & Education			4,872	4,872		4,872		4,872		23
24	Travel and Seminar			414	414		414	13,773	14,187		24
25	Other Admin. Staff Transportation			6,545	6,545		6,545		6,545		25
26	Insurance-Prop.Liab.Malpractice			182,453	182,453		182,453	8,273	190,726		26
27	Other (specify):*			72,000	72,000		72,000	(72,000)			27
28	<b>TOTAL General Administration</b>	643,304	34,678	2,540,349	3,218,331		3,218,331	(1,107,624)	2,110,707		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,541,785	637,032	2,964,286	8,143,103		8,143,103	(1,184,548)	6,958,555		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	13,788
	REPAIRS & MAINTENANCE	1,627
		0
		15,415
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	2,483
		0
		2,483
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	41,033
	ELECTRICITY	98,405
	WATER	43,022
	CABLE TV - LOBBY	0
		0
		182,460
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	4,027
	PAINTING & DECORATING	1,088
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	4,468
	ELEVATOR MAINTENANCE & REPAIR	7,258
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,575
	FIRE SERVICE	4,637
		0
		0
		0
		0
		26,053
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	17,616
	SECURITY SERVICE	0
		0
		0
		17,616
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	24,800
		24,800

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	863
	PHARMACY CONSULTANT XVIII B 39-2	2,568
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	144,418
	PSYCHOLOGIST XVIII B 46-2	7,090
		0
		154,939
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	0
	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	171
		0
		171
<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
<b>14</b>	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	0
<b>17</b>	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	895,655
	<b>DIRECTORS FEES</b>	
<b>18</b>	DIRECTORS FEES	0
<b>19</b>	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	33,061
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	425,074
		0
		458,135
<b>20</b>	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	43,645
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	66,576
	EMPLOYEE WANT ADS XIX F	6,264
	CONTRIBUTIONS VI 20 XIX F	1,360
	DUES & SUBSCRIPTIONS XIX F	10,450
	LICENSES & PERMITS XIX F	3,751
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	5,829
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	3,927
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	285
	PATIENT BACKGROUND CHECKS XIX F	2,000
		144,087
<b>21</b>	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	5,366
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	3,115
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	41,326
	MESSENGER SERVICE	3,910
		0
		53,717

LINE	SCHED REF	TOTAL
<b>22</b>	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	341,318
	UNEMPLOYMENT COMPENSATION XIX D	59,149
	WORKERS COMPENSATION INSURANC XIX D	96,035
	HOSPITALIZATION INSURANCE XIX D	199,389
	EMPLOYEE BENEFITS - OTHER XIX D	12,194
	EMPLOYEE PHYSICAL EXAMS XIX D	5,226
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	9,160
	CHICAGO HEAD TAX XIX D	0
		0
		722,471
<b>23</b>	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	4,872
		4,872
<b>24</b>	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	414
		414
<b>25</b>	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	6,545
		6,545
<b>26</b>	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	182,453
		182,453
<b>27</b>	<b>OTHER</b>	
	BAD DEBTS VI 24	72,000
		72,000

GRAND TOTAL COLUMN 3 OTHER

2,964,286

**DEERBROOK CARE CENTRE  
SCHEDULES  
12/31/2007**

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

TOTAL FOOD PURCHASE	254,097
LESS SALES TAX	<u>(2,107)</u>
NET FOOD	251,990

TOTAL PATIENT CENSUS	67,053
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	201,159

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	201,159
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	201,159

NET FOOD	251,990
DIVIDE TOTAL MEALS/YEAR	<u>201,159</u>

COST PER MEAL	1.25
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>0</b>

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

#0040741

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			39,113	39,113		39,113	260,213	299,326			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,300	1,300		1,300	118,858	120,158			32
33	Real Estate Taxes			86,806	86,806		86,806		86,806			33
34	Rent-Facility & Grounds			792,050	792,050		792,050	(741,521)	50,529			34
35	Rent-Equipment & Vehicles			34,935	34,935		34,935	10,548	45,483			35
36	Other (specify):* <b>STORAGE/MTG INS</b>			2,067	2,067		2,067	23,004	25,071			36
37	<b>TOTAL Ownership</b>			956,271	956,271		956,271	(328,898)	627,373			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		539,548	729,065	1,268,613		1,268,613		1,268,613			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			117,165	117,165		117,165		117,165			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		539,548	846,230	1,385,778		1,385,778		1,385,778			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,541,785	1,176,580	4,766,787	10,485,152		10,485,152	(1,513,446)	8,971,706			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>BHF 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	21,965	30		9
10	Interest and Other Investment Income	(164,804)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,107)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(3,115)	21		18
19	Entertainment	(43,645)	20		19
20	Contributions	(5,287)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(4,924)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(72,000)	27		24
25	Fund Raising, Advertising and Promotional	(66,576)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(5,829)	20		28
29	Other-Attach Schedule	(18,291)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (364,613)		\$	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)	(1,148,833)	PG 6-6D	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (1,148,833)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,513,446)		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: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 2,059	6	1
2	VACATION ACCRUAL	(4,447)	1	2
3	VACATION ACCRUAL	3,274	3	3
4	VACATION ACCRUAL	2,803	4	4
5	VACATION ACCRUAL	(1,909)	6	5
6	VACATION ACCRUAL	(8,327)	10	6
7	VACATION ACCRUAL	(401)	11	7
8	VACATION ACCRUAL	497	17	8
9	VACATION ACCRUAL	(3,751)	21	9
10	MEDICARE A CONSULTANT	(2,000)	19	10
11	MEDICARE B BILLING	(100)	19	11
12	MEDICARE A BILLING	(482)	19	12
13	MARKETING CONSULTANT	(5,507)	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>	(18,291)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number DEERBROOK CARE CENTRE# 0040741

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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	(4,447)	0	0	0	0	0	0	0	0	0	0	(4,447)	1
2	Food Purchase	(2,107)	0	0	0	0	0	0	0	0	0	0	(2,107)	2
3	Housekeeping	3,274	0	0	0	0	0	0	0	0	0	0	3,274	3
4	Laundry	2,803	0	0	0	0	0	0	0	0	0	0	2,803	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	150	0	0	0	0	0	0	0	0	0	0	150	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(327)</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>(327)</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	(8,327)	0	0	(67,869)	0	0	0	0	0	0	0	(76,196)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(401)	0	0	0	0	0	0	0	0	0	0	(401)	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>(8,728)</b>	<b>0</b>	<b>0</b>	<b>(67,869)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(76,597)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	497	0	(671,741)	0	0	(223,914)	0	0	0	0	0	(895,158)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(13,013)	9,564	57,494	979	(304,974)	0	0	0	0	0	0	(249,950)	19
20	Fees, Subscriptions & Promotions	(121,337)	0	530	145	593	0	0	0	0	0	0	(120,069)	20
21	Clerical & General Office Expenses	(6,866)	0	11,996	1,641	200,736	0	0	0	0	0	0	207,507	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	5,470	3,930	4,373	0	0	0	0	0	0	13,773	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	2,235	2,592	3,446	0	0	0	0	0	0	8,273	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>(212,719)</b>	<b>9,564</b>	<b>(594,016)</b>	<b>9,287</b>	<b>(95,826)</b>	<b>(223,914)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,107,624)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(221,774)</b>	<b>9,564</b>	<b>(594,016)</b>	<b>(58,582)</b>	<b>(95,826)</b>	<b>(223,914)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,184,548)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number DEERBROOK CARE CENTRE# 0040741

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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	21,965	232,536	555	249	4,908	0	0	0	0	0	0	260,213	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(164,804)	283,662	0	0	0	0	0	0	0	0	0	118,858	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	2,000	48,529	0	0	0	0	0	0	(741,521)	34
35	Rent-Equipment & Vehicles	0	0	3,565	4,039	2,944	0	0	0	0	0	0	10,548	35
36	Other (specify):*	0	23,004	0	0	0	0	0	0	0	0	0	23,004	36
37	<b>TOTAL Ownership</b>	<b>(142,839)</b>	<b>(252,848)</b>	<b>4,120</b>	<b>6,288</b>	<b>56,381</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(328,898)</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>(364,613)</b>	<b>(243,284)</b>	<b>(589,896)</b>	<b>(52,294)</b>	<b>(39,445)</b>	<b>(223,914)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,513,446)</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 NURSING 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		"		23,004	23,004	2
3	V	30 DEPRECIATION - BLDG IMP		"		232,144	232,144	3
4	V	30 DEPRECIATION - EQPT & FIX.		"		392	392	4
5	V	32 AMORTIZATION - MTG COST		"		1,256	1,256	5
6	V	32 MORTGAGE INTEREST		"		248,565	248,565	6
7	V	32 INTEREST - OTHER		"		33,841	33,841	7
8	V	19 ACCOUNTING		"		9,364	9,364	8
9	V	19 DATA PROCESSING		"		200	200	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 792,050			\$ 548,766	\$ * (243,284)	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		\$ 57,494	\$ 57,494
16	V	20 DUES & SUBSCRIPTIONS		"		530	530
17	V	21 CLERICAL		"		11,996	11,996
18	V	24 TRAVEL		"		5,470	5,470
19	V	26 INSURANCE		"		2,235	2,235
20	V	35 RENT - EQPT & VEH		"		3,565	3,565
21	V	17 ADMINISTRATIVE	671,741	"			(671,741)
22	V	30 DEPRECIATION		"		555	555
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		\$ 671,741			\$ 81,845	\$ * (589,896)

\* 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		\$ 55,562	\$ (67,869)
16	V	19 PROFESSIONAL FEES		"		979	979
17	V	20 DUES & SUBSCRIPTIONS		"		145	145
18	V	21 CLERICAL		"		1,641	1,641
19	V	24 TRAVEL		"		3,930	3,930
20	V	26 INSURANCE		"		2,592	2,592
21	V	30 DEPRECIATION		"		249	249
22	V	34 RENT		"		2,000	2,000
23	V	35 RENT - EQPT & VEH		"		4,039	4,039
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			\$ 71,137	\$ * (52,294)

\* 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	\$ 310,094	THE KENSINGTON GROUP, LLC		\$ 5,120	\$ (304,974)
16	V	20 DUES & SUBSCRIPTIONS		"		593	593
17	V	21 CLERICAL		"		200,736	200,736
18	V	24 TRAVEL		"		4,373	4,373
19	V	26 INSURANCE		"		3,446	3,446
20	V	30 DEPRECIATION		"		4,908	4,908
21	V	34 RENT		"		48,529	48,529
22	V	35 RENT -EQPT & VEH		"		2,944	2,944
23	V	17 ADMINISTRATIVE		"			
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		\$ 310,094			\$ 270,649	\$ * (39,445)

\* 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	\$ 223,914	CHESTERFIELD, LLC		\$	\$ (223,914)
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>		\$ 223,914			\$ 0	\$ * (223,914)

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

Facility Name &amp; ID Number

DEERBROOK CARE CENTRE

# 0040741

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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: **01/01/2007**

Ending: **2/31/2007**

**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	345796	368,840	7	\$ 316,248	\$ 67,053	\$ 57,494	1
2	20	DUES & SUBSCRIPTIONS	345796	368,840	7	2,914	67,053	530	2
3	21	CLERICAL	345796	368,840	7	65,982	67,053	11,995	3
4	24	TRAVEL	345796	368,840	7	30,090	67,053	5,470	4
5	26	INSURANCE	345796	368,840	7	12,294	67,053	2,235	5
6	35	RENT - EQPT & VEHICLES	345796	368,840	7	19,611	67,053	3,565	6
7	30	DEPRECIATION	345796	368,840	7	3,051	67,053	555	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					\$ 450,190	\$	\$ 81,844	25

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

# **0040741** Report Period Beginning: **01/01/2007**

Ending: **2/31/2007**

**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 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

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	10	NURSING	DIRECT HOURS	1	\$ 55,562	\$ 55,562	1	\$ 55,562	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	553,355	8,078		67,053	979	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	553,355	1,197		67,053	145	3
4	21	CLERICAL	PATIENT DAYS	553,355	13,541		67,053	1,641	4
5	24	TRAVEL	PATIENT DAYS	553,355	32,426		67,053	3,930	5
6	26	INSURANCE	PATIENT DAYS	553,355	21,389		67,053	2,592	6
7	30	DEPRECIATION	PATIENT DAYS	553,355	2,056		67,053	249	7
8	34	RENT	PATIENT DAYS	553,355	16,500		67,053	2,000	8
9	35	RENT - EQPT & VEH	PATIENT DAYS	553,355	33,327		67,053	4,039	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				\$ 184,076	\$ 55,562		\$ 71,137	25

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

# **0040741** Report Period Beginning: **01/01/2007**

Ending: **2/31/2007**

**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 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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	19	PROFESSIONAL FEES	PATIENT DAYS	553,355	11	\$ 42,255	\$ 67,053	\$ 5,120	1	
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	553,355	11	4,892	67,053	593	2	
3	21	CLERICAL	PATIENT DAYS	553,355	11	203,886	67,053	24,707	3	
4	24	TRAVEL	PATIENT DAYS	553,355	11	36,083	67,053	4,373	4	
5	26	INSURANCE	PATIENT DAYS	553,355	11	28,435	67,053	3,446	5	
6	30	DEPRECIATION	PATIENT DAYS	553,355	11	40,500	67,053	4,908	6	
7	34	RENT	PATIENT DAYS	553,355	11	400,473	67,053	48,529	7	
8	35	RENT - EQPT VEH	PATIENT DAYS	553,355	11	24,297	67,053	2,944	8	
9									9	
10	21	CLERICAL	DIRECT HOURS	1	1	176,029	176,029	1	176,029	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					\$ 956,850	\$ 176,029	\$ 270,649	25	

Facility Name & ID Number

DEERBROOK CARE CENTRE

# 0040741

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

**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	4,575,221	12/38	5.4000	248,565	2						
3	GMAC		X	LOAN COST	AMORT - 35 YEARS		43,959	38,875			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	374,822	VARIES	VARIES	33,841	7						
8												8						
9	TOTAL Facility Related				\$61,407.35		\$ 5,053,391	\$ 4,988,918			\$ 284,962	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						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 5,053,391	\$ 4,988,918			\$ 284,962	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 2006 report.		\$	<b>93,444</b>	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.)		\$	<b>89,650</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(3,794)</b>	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>90,600</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>86,806</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	<b>88,752</b>	8
	2003	<b>88,433</b>	9
	2004	<b>91,416</b>	10
	2005	<b>91,618</b>	11
	2006	<b>89,650</b>	12

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**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 2006 TAX BILL.**

**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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

**2006 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 2006 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 2006.

(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>89,649.94</u>	\$ <u>89,649.94</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>89,649.94</u>	\$ <u>89,649.94</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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:

01/01/2007 Ending:

12/31/2007

**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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>	<u>105,000</u>		\$ <u>27,500</u>	<u>1</u>
2	<u>754 BASIS ADJ</u>			<u>13,220</u>	<u>2</u>
3	<b>TOTALS</b>	<b>105,000</b>		\$ <b>40,720</b>	<b>3</b>

Facility Name &amp; ID Number DEERBROOK CARE CENTRE

# 0040741

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**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	\$ 1,703,303	4
5			1980	168,687		20			168,687	5
6	754 ADJ		1992	125,584	4,566	27.5	4,566		70,594	6
7	754 ADJ		2001	29,192	1,061	27.5	1,061		7,433	7
8										8
	<b>Improvement Type**</b>									
9	*****RELATED PARTY - DEERBROOK NURSING CENTRE*****									
10	IMPROVEMENTS		1984	33,823		20			33,823	10
11	IMPROVEMENTS		1986	21,535		20			21,535	11
12	IMPROVEMENTS		1987	78,860	2,867	27.5	1,526	(1,341)	78,860	12
13	IMPROVEMENTS		1988	48,614	1,767	27.5	1,767		29,987	13
14	IMPROVEMENTS		1989	60,430	2,198	27.5	2,198		36,561	14
15	IMPROVEMENTS		1990	30,485	1,109	27.5	1,109		16,720	15
16	IMPROVEMENTS		1991	53,134	1,934	27.5	1,934		27,966	16
17	IMPROVEMENTS		1992	117,363	4,269	27.5	4,269		57,658	17
18	IMPROVEMENTS		1993	29,335	1,066	27.5	1,066		13,605	18
19	IMPROVEMENTS		1993	29,864	1,087	27.5	1,087		11,950	19
20	IMPROVEMENTS		1994	37,711	1,372	27.5	1,372		18,264	20
21	VINYL SLIDER UNITS		1995	3,070	112	27.5	112		1,395	21
22	DOORS		1995	2,564	93	27.5	93		1,159	22
23	ROOF		1996	24,069	875	27.5	875		10,099	23
24	OUR TOWN		1996	74,400	2,706	27.5	2,706		29,869	24
25	ROOF/REMODEL KITCHEN/DUMPSTER/FLOORS		1997	440,180	16,007	27.5	16,007		166,465	25
26	ALZHEIMERS WING CONSTRUCTION		1997	1,590,575	57,839	27.5	57,839		597,057	26
27	OUR TOWN		1998	21,500	782	27.5	782		7,787	27
28	ALZHEIMERS WING CONSTRUCTION - FINAL DRAW		1998	17,009	618	27.5	618		6,155	28
29	DINING ROOM FLOOR - TILES		1998	30,000	1,091	27.5	1,091		10,865	29
30	DOOR ALARM SYSTEMS		1998	24,760	901	27.5	901		8,964	30
31	SPRINKLERS		1998	3,500	128	27.5	128		1,266	31
32	DINING ROOM - WALLPAPER/TILE BASE		1998	14,900	542	27.5	542		5,352	32
33	RENOVATE 2 ROOMS/REPLACE ELEVATOR FLOORS		1998	9,400	342	27.5	342		3,349	33
34	REMODELING OF ELEVATOR - LOBBY		1998	7,050	257	27.5	257		2,487	34
35	LANDSCAPING		1998	2,815	103	27.5	103		992	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:

01/01/2007 Ending: 12/31/2007

## 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	\$ 127	27.5	\$ 127	\$	\$ 1,241	37
38	DINING & RESIDENT ROOM FLOORS	1998	15,268	555	27.5	555		5,342	38
39	HOT WATER TANK	1998	1,780	64	27.5	64		624	39
40	REMODELING - SHOWER ROOM	1998	3,830	140	27.5	140		1,304	40
41	ASPHALT PARKING LOT & SPEED BUMPS	1998	17,156	624	27.5	624		5,746	41
42	WALLCOVERING/WINDOW TRMETS/TILES	1998	18,635	677	27.5	677		6,242	42
43	REMODELING - RESIDENT ROOMS	1998	37,050	1,348	27.5	1,348		12,179	43
44	WINDOW TREATMENTS /REMODEL RMS	1999	18,066	657	27.5	657		5,886	44
45	FIRE ALARMS & HVAC/CEILING/HALLS/CALL LIGHTS	1999	25,000	909	27.5	909		8,068	45
46	REPAIR & REMODEL HALLWAY/DOOR/MONITOR SYS	1999	23,425	852	27.5	852		7,490	46
47	REMODEL ROOMS/DOOR MONITOR SYS	1999	45,989	1,673	27.5	1,673		14,562	47
48	REMODEL RMS/LANDSCAPING	1999	53,572	1,948	27.5	1,948		16,802	48
49	WALLCOVERING/WINDOW TRMETS/TILES	1999	6,950	252	27.5	252		2,160	49
50	REMODELING RMS	1999	16,205	590	27.5	590		4,983	50
51	WALLCOVERING/FLOOR TILES/HANDRAILS	1999	28,464	1,035	27.5	1,035		8,668	51
52	REMODELING RMS	1999	47,115	1,714	27.5	1,714		14,205	52
53	NURSE STATION/ELEVATOR DOOR	1999	18,030	655	27.5	655		5,384	53
54	REMODELING ROOMS/WINDOW TRMETS	1999	170,712	6,208	27.5	6,208		49,916	54
55	FIRE DAMPERS	2000	4,950	180	27.5	180		1,433	55
56	REMODELING- WASHROOMS/MEDICAL & REC. RM	2000	35,550	1,292	27.5	1,292		10,073	56
57	FENCES	2000	3,557	130	27.5	130		996	57
58	WALLCOVERING/WINDOW TRMT - RES & DINING RMS	2000	69,939	2,543	27.5	2,543		19,179	58
59	FIREWALL/RESIDENT ROOM CEILINGS/TUCKPOINTING	2000	85,160	3,097	27.5	3,097		23,351	59
60	MAGNETIC DOOR/STEAMER	2000	16,334	452	27.5	452		3,480	60
61	HANDRAILS	2000	8,101	294	27.5	294		2,199	61
62	REMODELING - NURSE STATION/CORRIDOR /DINING RM	2000	126,731	4,609	27.5	4,609		34,370	62
63	PTAC UNITS	2000	3,550	129	27.5	129		962	63
64	CONCRETE PAVING	2000	11,700	426	27.5	426		3,171	64
65	IRRIGATION SYSTEM & ROOM PLATES	2000	10,425	379	27.5	379		2,795	65
66	DESIGN & BUILD ENABLING GARDEN	2000	19,832	1,322	15	1,322		9,920	66
67	CARPETING/WINDOW TREATMENT	2000	14,549	529	27.5	529		3,857	67
68	PTAC UNITS	2000	3,550	129	27.5	129		941	68
69	REMODELING - BREAK ROOM & MEDICATION ROOM	2000	39,886	1,451	27.5	1,451		10,574	69
70	TOTAL (lines 4 thru 69)		\$ 5,984,682	\$ 172,432		\$ 194,190	\$ 21,758	\$ 3,448,310	70

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

## 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	\$ 172,432		\$ 194,190	\$ 21,758	\$ 3,448,310	1
2	SIDEWALK	2000	2,240	82	27.5	82		585	2
3	REMODELING - RESIDENT RMS, LOBBY, MAILROOM	2000	60,826	2,212	27.5	2,212		15,945	3
4	PTAC UNITS	2000	4,644	169	27.5	169		1,218	4
5	WOOD BLINDS FOR OOFICES	2001	3,538	128	27.5	128		896	5
6	CUBICLES	2001	8,332	303	27.5	303		2,108	6
7	REMODEL - ALL 2ND FLOOR RESIDENT ROOMS	2001	370,353	13,467	27.5	13,467		93,704	7
8	VERTICAL BLINDS FOR 2ND FLOOR ROOMS	2001	3,847	140	27.5	140		974	8
9	CARPETING FIRST FLOOR OFFICES/PLUMBING	2001	8,850	322	27.5	322		2,187	9
10	DROP & CHANGE SPRINKLER HEADS IN CORRIDOR	2001	5,097	186	27.5	186		1,242	10
11	REPAIR CEILING ON FIRST FLOOR	2001	25,000	909	27.5	909		6,098	11
12	REPAIR CORRIDOR IN LAUNDRY AREA	2001	10,000	363	27.5	363		2,380	12
13	TEN TON COMPRESSOR FOR KITCHEN UNIT	2001	4,441	162	27.5	162		1,014	13
14	INSTALL TILE FLOORING IN SERVICE HALLWAY	2002	11,300	411	27.5	411		2,449	14
15	INSTALL ELECTRICAL OUTLETS IN RMS 101 TO 104	2002	8,000	291	27.5	291		1,613	15
16	INSTALL PIPE RUN FR. ELECTRICAL CLOSET TO RM 104	2002	1,186	43	27.5	43		238	16
17	FRIEDRICH 11700 BTU PTAC UNITS -2	2002	1,337	48	27.5	48		270	17
18	AMANA - PTAC 12000 BTU HEAT & 11700 PTAC UNIT	2002	1,379	50	27.5	50		273	18
19	REPLACE FIRE PANEL	2003	4,500	163	27.5	163		758	19
20	2 CANVAS AWNINGS	2003	1,650	110	15	110		454	20
21	RESTRIP AND ASPHALT SEAL PARKING LOT	2003	6,535	435	15	435		1,797	21
22	INSTALLATION OF 4 BATHRM WATER SHUT OFF VALVES	2004	2,360	86	27.5	86		340	22
23	WIRING AND INSTALLATION OF TV'S IN RES. ROOMS	2004	20,700	752	27.5	752		2,729	23
24	CONCRETE WORK DONE TO B WING SIDE WALK	2004	5,540	202	27.5	202		713	24
25	REPAIR/REPLACEMENT OF ELECTRICAL LIGHTING COM	2004	7,350	268	27.5	268		947	25
26	INSTALL 80 SOLID CORE, FIRE RATED DOORS	2004	75,115	2,732	27.5	2,732		8,991	26
27	INSTALL NEW ELECTRICAL WIRING & PIPING - 1ST FLR	2004	33,552	1,220	27.5	1,220		3,711	27
28	INSTALLATION OF 20 AMP CIRCUIT IN STORAGE CLOSET	2005	822	30	27.5	30		86	28
29	REMOVED OLD & INSTALLED NEW WATER RECOND. SYS	2005	8,360	304	27.5	304		632	29
30	FIRE SPRINKLER SYSTEM	2005	2,060	75	27.5	75		178	30
31	MORTAR WORK & FIRE CAULK - 1ST FLOOR, A,B,C WING								31
32	2ND FLOOR A,B,C WING, SHORTAGE RM, & DINING RM.	2005	9,740	354	27.5	354		841	32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,693,336	\$ 198,449		\$ 220,207	\$ 21,758	\$ 3,603,681	34

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

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	\$ 198,449		\$ 220,207	\$ 21,758	\$ 3,603,681	1
2	2006	321,289	11,683	27.5	11,683		19,959	2
3	2006	2,150	79	27.5	79		147	3
4	2006	4,791	175	27.5	175		211	4
5								5
6								6
7		ADJ. TO SL	21,758			(21,758)		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	\$ 232,144		\$ 232,144	\$	\$ 3,623,998	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	\$ 600,178	\$ 25,400	\$ 57,281	\$ 31,881	3-10 YRS	\$ 410,834	71
72	Current Year Purchases	61,192	12,239	3,060	(9,179)	3-10 YRS	3,060	72
73	Fully Depreciated Assets	128,265					128,265	73
74	RELATED PARTY	3,918	6,104	6,104		3-10 YRS	2,156	74
75	TOTALS	\$ 793,553	\$ 43,743	\$ 66,445	\$ 22,702		\$ 544,315	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	NURSING HOME USE	2003 FORD CLUB WAGON	2007	\$ 7,368	\$ 1,474	\$ 737	\$ (737)	10	\$ 737	76
77										77
78										78
79										79
80	TOTALS			\$ 7,368	\$ 1,474	\$ 737	\$ (737)		\$ 737	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)	\$ 7,863,207	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 277,361	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 299,326	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 21,965	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,169,050	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: \$ **28,796** 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	ADMINISTRATIVE	2005 CAMRY	\$ 389.00	\$ 4,279	17
18	ADMINISTRATIVE	2007 HONDA ACCORD	465.00	1,860	18
19					19
20					20
21	<b>TOTAL</b>		\$ 854.00	\$ 6,139	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. \_\_\_\_\_ /2008 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

\* 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		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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	\$		\$ 322,426	\$		\$ 322,426	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			102,628			102,628	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			304,011			304,011	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 prescrpts				447,473		447,473	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					92,075		92,075	13
14	<b>TOTAL</b>			\$		\$ 729,065	\$ 539,548		\$ 1,268,613	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: 01/01/2007

Ending:

12/31/2007

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(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	\$ 1,670,068	\$ 2,044,980	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>178,625</u> )	2,783,564	2,783,564	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	55,566	119,903	6
7	Other Prepaid Expenses	21,367	21,367	7
8	Accounts Receivable (owners or related parties)	4,820	32,820	8
9	Other(specify): <u>ESCROW DEPOSITS</u>		570,468	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 4,535,385	\$ 5,573,102	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable	1,506,420	1,131,598	11
12	Long-Term Investments	1,955	1,955	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	797,002	797,002	16
17	Accumulated Depreciation (book methods)	(716,088)	(4,212,519)	17
18	Deferred Charges		130,068	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</b> (sum of lines 11 thru 23)	\$ 1,589,289	\$ 4,958,479	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 6,124,674	\$ 10,531,581	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 621,090	\$ 626,000	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	247,133	247,133	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	150,880	150,880	30
31	Accrued Taxes Payable (excluding real estate taxes)	23,865	23,865	31
32	Accrued Real Estate Taxes(Sch.IX-B)		90,600	32
33	Accrued Interest Payable		20,589	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>DUT TO LESSOR</u>	1,413,738		36
37	<u>MANAGEMENT FEES</u>	303,191	303,191	37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 2,759,897	\$ 1,462,258	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,575,221	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</b> (sum of lines 39 thru 44)	\$	\$ 4,575,221	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 2,759,897	\$ 6,037,479	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 3,364,777	\$ 4,494,102	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 6,124,674	\$ 10,531,581	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>2,256,994</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>1065 REFUND</b>	<b>272</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>2,257,266</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>1,107,057</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>SEC 754 ADJ</b>	<b>454</b>	<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>1,107,511</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>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>3,364,777</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	\$ 11,426,779	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 11,426,779	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>	\$	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	76	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>	\$ 76	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	164,804	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 164,804	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>NET VENDING COMMISSIONS</b>	550	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 550	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 11,592,209	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,291,047	31
32	Health Care	3,633,725	32
33	General Administration	3,218,331	33
	<b>B. Capital Expense</b>		
34	Ownership	956,271	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	1,268,613	35
36	Provider Participation Fee	117,165	36
	<b>D. Other Expenses (specify):</b>		
37	<b>OUT-OF-PERIOD EXPENSES</b>		37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 10,485,152	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,107,057	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,107,057	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: **01/01/2007**

Ending:

**12/31/2007**

**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	1,866	2,126	\$ 98,265	\$ 46.22	1
2	Assistant Director of Nursing	1,138	1,546	49,240	31.85	2
3	Registered Nurses	36,746	39,772	1,166,875	29.34	3
4	Licensed Practical Nurses	24,205	26,168	578,934	22.12	4
5	CNAs & Orderlies	100,554	106,388	1,094,672	10.29	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	5,601	6,131	135,307	22.07	9
10	Activity Assistants	7,659	8,183	61,313	7.49	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	11,488	12,474	174,522	13.99	14
15	Cook Helpers/Assistants	15,697	16,460	130,052	7.90	15
16	Dishwashers					16
17	Maintenance Workers	5,111	5,658	80,840	14.29	17
18	Housekeepers	19,025	20,467	217,737	10.64	18
19	Laundry	10,231	10,602	77,361	7.30	19
20	Administrator	1,951	2,739	123,951	45.25	20
21	Assistant Administrator	1,950	2,086	65,801	31.54	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	21,615	24,281	453,552	18.68	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	1,949	2,162	33,363	15.43	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	266,786	287,243	\$ 4,541,785 *	\$ 15.81	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	208	\$ 13,788	1-3	35
36	Medical Director	248	24,800	9-3	36
37	Medical Records Consultant	12	863	10-3	37
38	Nurse Consultant	965	144,418	10-3	38
39	Pharmacist Consultant	192	2,568	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	3	171	12-3	45
46	Other(specify) <u>PSYCHOLOGIST</u>	84	7,090	10-3	46
47				10-3	47
48					48
49	TOTAL (lines 35 - 48)	1,712	\$ 193,698		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-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13												
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year							
																	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
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																								
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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: 01/01/2007

Ending: 12/31/2007

**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 - \$10155.60
- (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. \$ 11,628 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees