

Facility Name & ID Number Elm Brook Health Care & Rehabilitation Centre# 0044818 Report Period Beginning: 1-Jan-2007 Ending: 31-Dec-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	<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>23,570</u>	<u>3,793</u>	<u>6,181</u>	<u>33,544</u>	8
9	SNF/PED					9
10	ICF	<u>19,359</u>	<u>1,881</u>	<u>14</u>	<u>21,254</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>42,929</u>	<u>5,674</u>	<u>6,195</u>	<u>54,798</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.41%

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 5,635Medicare 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 2007 Fiscal Year: 31st Dec 2007

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

Facility Name & ID Number Elm Brook Health Care & Rehabilitation Cen # 0044818 Report Period Beginning: 1-Jan-2007 Ending: 31-Dec-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
	A. General Services										
1	Dietary	417,278	59,577	12,586	489,441		489,441		489,441		1
2	Food Purchase		361,137		361,137	(16,749)	344,388	(229)	344,159		2
3	Housekeeping	347,264	60,299		407,563		407,563		407,563		3
4	Laundry	102,620	53,485		156,105		156,105		156,105		4
5	Heat and Other Utilities			315,151	315,151		315,151		315,151		5
6	Maintenance	92,214	70,856	65,459	228,529		228,529	2,839	231,368		6
7	Other (specify):*										7
8	TOTAL General Services	959,376	605,354	393,196	1,957,926	(16,749)	1,941,177	2,610	1,943,787		8
	B. Health Care and Programs										
9	Medical Director			18,900	18,900		18,900		18,900		9
10	Nursing and Medical Records	3,180,432	367,654	5,184	3,553,270		3,553,270		3,553,270		10
10a	Therapy		12,142	10,598	22,740		22,740		22,740		10a
11	Activities	390,865	36,814	4,325	432,004		432,004		432,004		11
12	Social Services	114,291		1,026	115,317		115,317		115,317		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* **Dental Service**			5,668	5,668		5,668		5,668		15
16	TOTAL Health Care and Programs	3,685,588	416,610	45,701	4,147,899		4,147,899		4,147,899		16
	C. General Administration										
17	Administrative	97,544		226,800	324,344		324,344	(111,452)	212,892		17
18	Directors Fees										18
19	Professional Services			108,214	108,214		108,214	7,405	115,619		19
20	Dues, Fees, Subscriptions & Promotions			34,241	34,241		34,241	(23,918)	10,323		20
21	Clerical & General Office Expenses	184,909	60,537	38,414	283,860		283,860	67,195	351,055		21
22	Employee Benefits & Payroll Taxes			763,144	763,144	16,749	779,893	20,686	800,579		22
23	Inservice Training & Education			10,647	10,647		10,647	1,641	12,288		23
24	Travel and Seminar			5,949	5,949		5,949	3,395	9,344		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			9,741	9,741		9,741		9,741		26
27	Other (specify):* *Payroll Taxes (Sch VII)							16,459	16,459		27
28	TOTAL General Administration	282,453	60,537	1,197,150	1,540,140	16,749	1,556,889	(18,589)	1,538,300		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,927,417	1,082,501	1,636,047	7,645,965		7,645,965	(15,979)	7,629,986		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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			76,166	76,166		76,166	367,179	443,345		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			246,913	246,913		246,913	560,634	807,547		32
33	Real Estate Taxes			57,450	57,450		57,450		57,450		33
34	Rent-Facility & Grounds			1,500,000	1,500,000		1,500,000	(1,500,000)			34
35	Rent-Equipment & Vehicles			5,306	5,306		5,306		5,306		35
36	Other (specify):* *Amortization of Goodwill*			195,618	195,618		195,618		195,618		36
37	TOTAL Ownership			2,081,453	2,081,453		2,081,453	(572,187)	1,509,266		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		230,165	629,402	859,567		859,567		859,567		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		230,165	727,952	958,117		958,117		958,117		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,927,417	1,312,666	4,445,452	10,685,535		10,685,535	(588,166)	10,097,369		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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	104,788	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	(229)	2		13
14	Non-Care Related Interest	(5,709)	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	(964)	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	(2,715)	21		24
25	Fund Raising, Advertising and Promotional	(54,189)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,690)	20		28
29	Other-Attach Schedule ** Page 5A attached **	2,839	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 39,031		\$	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)	(627,197)	6 & 6A	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (627,197)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (588,166)		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 Health Care & Rehabilitation Centre

ID# 0044818

Report Period Beginning: 1-Jan-2007

Ending: 31-Dec-2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Painting & Decorating (incurred in 2007)	\$ (1,260)	6 1
2	Painting & Decorating (allocated for 2007)	4,099	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	2,839	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elm Brook Health Care & Rehabilitation Centre

0044818

Report Period Beginning:

1-Jan-2007

Ending:

31-Dec-2007

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	(229)	0	0	0	0	0	0	0	0	0	0	(229)	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	2,839	0	0	0	0	0	0	0	0	0	0	2,839	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	2,610	0	0	0	0	0	0	0	0	0	0	2,610	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	(11,452)	0	0	0	0	0	0	0	0	0	(11,452)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	6,455	950	0	0	0	0	0	0	0	0	7,405	19
20	Fees, Subscriptions & Promotions	(58,979)	35,061	0	0	0	0	0	0	0	0	0	(23,918)	20
21	Clerical & General Office Expenses	(2,715)	69,910	0	0	0	0	0	0	0	0	0	67,195	21
22	Employee Benefits & Payroll Taxes	0	20,686	0	0	0	0	0	0	0	0	0	20,686	22
23	Inservice Training & Education	0	1,641	0	0	0	0	0	0	0	0	0	1,641	23
24	Travel and Seminar	(964)	4,359	0	0	0	0	0	0	0	0	0	3,395	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	16,459	0	0	0	0	0	0	0	0	0	16,459	27
28	TOTAL General Administration	(62,658)	43,119	950	0	(18,589)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(60,048)	43,119	950	0	(15,979)	29							

STATE OF ILLINOIS

Facility Name & ID Number Elm Brook Health Care & Rehabilitation Centre

0044818

Report Period Beginning:

1-Jan-2007 Ending:

Summary B

31-Dec-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	104,788	817	261,574	0	0	0	0	0	0	0	0	367,179	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,709)	(164,708)	731,051	0	0	0	0	0	0	0	0	560,634	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	99,079	(163,891)	(507,375)	0	(572,187)	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)	39,031	(120,772)	(506,425)	0	(588,166)	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	\$ 226,800	Lancaster, Ltd.	100.00%	\$	\$ (226,800)	1
2	V	17 Officers Salary		Lancaster, Ltd.	100.00%	40,954	40,954	2
3	V	19 Professional Services		Lancaster, Ltd.	100.00%	6,455	6,455	3
4	V	21 Clerical Expenses		Lancaster, Ltd.	100.00%	69,910	69,910	4
5	V	22 Employee Benefits		Lancaster, Ltd.	100.00%	20,686	20,686	5
6	V	24 Seminars & Travel		Lancaster, Ltd.	100.00%	4,359	4,359	6
7	V	17 Administrative Consulting		Lancaster, Ltd.	100.00%	74,394	74,394	7
8	V	20 Marketing and Fees		Lancaster, Ltd.	100.00%	34,099	34,099	8
9	V	32 Interest	167,964	Lancaster, Ltd.	100.00%	3,256	(164,708)	9
10	V	30 Depreciation		Lancaster, Ltd.	100.00%	817	817	10
11	V	20 Dues, Fees and Subscriptions		Lancaster, Ltd.	100.00%	962	962	11
12	V	27 Payroll Taxes (Staff & Officers)		Lancaster, Ltd.	100.00%	16,459	16,459	12
13	V	23 Education & Inservice		Lancaster, Ltd.	100.00%	1,641	1,641	13
14	Total		\$ 394,764			\$ 273,992	\$ * (120,772)	14

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

Facility Name & ID Number Elm Brook Health Care & Rehabilitation Centre# 0044818Report Period Beginning: 1-Jan-2007 Ending: 31-Dec-2007

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	78,949	Elmbrook Associates		810,000	731,051	16
17	V	30 Depreciation		Elmbrook Associates		261,574	261,574	17
18	V	19 Accounting Fees		Elmbrook Associates		950	950	18
19	V							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		\$ 1,578,949			\$ 1,072,524	\$ * (506,425)	39

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

Facility Name & ID Number Elm Brook Health Care & Rehabilitation Center # 0044818 Report Period Beginning: 1-Jan-2007 Ending: 31-Dec-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	Christopher Vicere	VP-Finance	Administrative		See attached	5	10.42	Lancaster	\$ 20,477	17-7	1
2	Cheryl Morris	VP-Operations	Administrative		See attached	5	10.42	Lancaster	20,477	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	\$ 40,954		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 Health Care & Rehabilitation Centre # 0044818 Report Period Beginning: 1-Jan-2007 Ending: -Dec-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 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	\$ 196,583	\$ 196,583	5	\$ 20,477	1
2	27	Christopher Vicere-payroll tax	Hours Worked	48	7	9,894		5	1,031	2
3	17	Cheryl Morris	Hours Worked	48	7	196,583	196,583	5	20,477	3
4	27	Cheryl Morris-payroll tax	Hours Worked	48	7	9,894		5	1,031	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13	19	Professional Services	Management Fees	1,694,700	7	48,231		226,800	6,455	13
14	21	Clerical Expenses	Management Fees	1,694,700	7	522,379	452,822	226,800	69,910	14
15	22	Employee Benefits	Management Fees	1,694,700	7	154,573		226,800	20,686	15
16	24	Seminars & Travel	Management Fees	1,694,700	7	32,569		226,800	4,359	16
17	17	Administrative Consulting	Management Fees	1,694,700	7	555,885	555,885	226,800	74,394	17
18	20	Marketing and Fees	Management Fees	1,694,700	7	254,796	183,072	226,800	34,099	18
19	32	Interest	Management Fees	1,694,700	7	24,333		226,800	3,256	19
20	30	Depreciation	Management Fees	1,694,700	7	6,106		226,800	817	20
21	20	Dues, Fees and Subscriptions	Management Fees	1,694,700	7	7,190		226,800	962	21
22	27	Payroll Taxes	Management Fees	1,694,700	7	107,574		226,800	14,397	22
23	23	Education & Inservice	Management Fees	1,694,700	7	12,265		226,800	1,641	23
24	32	*Direct Interest*								24
25	TOTALS					\$ 2,138,857	\$ 1,584,945		\$ 273,992	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						3,256	6									
7	Harston Investments		X	Working Capital						810,000	7									
8											8									
9	TOTAL Facility Related					\$	\$			\$ 813,256	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$				14									
15	TOTALS (line 9+line14)					\$	\$			\$ 813,256	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A Less: Interest Income (5,709)
807,547
 Page 4 Line 32

* 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 2006 report.		\$ 55,000	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.)		\$ 54,950	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (50)	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 57,500	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.		\$ 57,450	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	49,495	8
	2003	45,836	9
	2004	47,519	10
	2005	52,417	11
	2006	54,950	12
* Accrual for 2007 report is based on 2006 Taxes adjusted for inflation			
FOR BHF USE ONLY			
	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

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 Elm Brook Health Care & 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 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>03-26-207-022</u>	<u>Long-Term Health Care</u>	\$ <u>4,323.68</u>	\$ <u>4,323.68</u>
2. <u>03-26-207-025</u>	<u>Long-Term Health Care</u>	\$ <u>50,625.90</u>	\$ <u>50,625.90</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>54,949.58</u>	\$ <u>54,949.58</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.

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

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	180		2004		\$ 6,815,732	\$ 174,755	40	\$ 174,762	\$ 7	\$ 633,513	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Front Sign and Awnings		2001	5,750	340	15	340		2,822	9
10		General Construction - Phase I		2001	191,999	4,923	20	4,923		29,743	10
11		Fire Security		2001	9,021	231	20	231		1,396	11
12		Electrical		2001	3,045	78	20	78		471	12
13		Rehab Satellite		2002	86,171	2,209	10	8,617	6,408	43,803	13
14		General Construction - Phase II		2002	538,782	13,814	10	53,878	40,064	273,880	14
15		Faux Wood Blinds		2003	3,502	202	5	700	498	3,004	15
16		New Roof		2003	36,561	937	10	3,656	2,719	14,929	16
17		Upgrade Elevators		2004	34,190	877	20	1,710	833	5,415	17
18		Construction & Design Cost		2004	15,873	407	10	1,588	1,181	6,343	18
19		Elevator Fire Alarm Equipment		2005	9,360	240	10	936	696	2,808	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	\$ 199,013		\$ 251,419	\$ 52,406	\$ 1,018,127	70

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

Facility Name & ID Number Elm Brook Health Care & Rehabilitation Centre # 0044818 Report Period Beginning: 1-Jan-2007 Ending: 31-Dec-2007

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	\$ 945,932	\$ 125,423	\$ 171,320	\$ 45,897	7	\$ 626,403	71
72	Current Year Purchases	32,547	6,510	3,400	(3,110)	7	3,400	72
73	Fully Depreciated Assets	157,260	6,793	16,388	9,595	7	157,260	73
74	**Lancaster Allocation**		818	818		7	4,997	74
75	TOTALS	\$ 1,135,739	\$ 139,544	\$ 191,926	\$ 52,382		\$ 792,060	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)		\$ 9,450,725	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 338,557	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 443,345	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 104,788	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 1,810,187	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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

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

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 5,306 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	\$		\$ 269,087	\$		\$ 269,087	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			80,804			80,804	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			277,373			277,373	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	39-3	hrs			2,138			2,138	8
9	Pharmacy	39-2	# of prescrpts				150,469		150,469	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					61,695		61,695	13
	Speciality Beds	39-2					18,001		18,001	
14	TOTAL			\$		\$ 629,402	\$ 230,165		\$ 859,567	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 Health Care & Rehabilitation Centre # 0044818 Report Period Beginning: 1-Jan-2007 Ending: 31-Dec-2007

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 31-Dec-2007 (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	\$ 4,089	\$ 9,089	1
2	Cash-Patient Deposits	37,159	37,159	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,798,656	2,798,656	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	59,978	59,978	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,120	1,120	8
9	Other(specify): **Refundable Deposit**	2,540	2,540	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,903,542	\$ 2,908,542	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	488,358	1,135,739	16
17	Accumulated Depreciation (book methods)	(447,090)	(1,688,587)	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**	(700,964)	(700,964)	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,654,172	\$ 9,995,443	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,557,714	\$ 12,903,985	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 216,356	\$ 216,356	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	37,339	37,339	28
29	Short-Term Notes Payable	4,865,533	3,206,970	29
30	Accrued Salaries Payable	503,057	503,057	30
31	Accrued Taxes Payable (excluding real estate taxes)	19,352	19,352	31
32	Accrued Real Estate Taxes(Sch.IX-B)	57,500	57,500	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)	\$ 5,699,137	\$ 4,040,574	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)	\$ 5,699,137	\$ 12,140,574	46
47	TOTAL EQUITY(page 18, line 24)	\$ (141,423)	\$ 763,411	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,557,714	\$ 12,903,985	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,339,185)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,339,185)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,302,238)	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)	\$ 2,197,762	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)	\$ (141,423)	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	\$ (3,440,776)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,440,776)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(795,813)	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)	\$ 4,204,187	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)	\$ 763,411	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Elm Brook Health Care & Rehabilitation Centre # 0044818 Report Period Beginning: 1-Jan-2007 Ending: 31-Dec-2007

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	\$ 9,509,693	1
2	Discounts and Allowances for all Levels	(1,772,507)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,737,186	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,408,905	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,408,905	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	193,572	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,866	19
20	Radiology and X-Ray	5,050	20
21	Other Medical Services	26,009	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 231,497	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	5,709	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,709	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)	\$ 9,383,297	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,957,926	31
32	Health Care	4,147,899	32
33	General Administration	1,540,140	33
B. Capital Expense			
34	Ownership	2,081,453	34
C. Ancillary Expense			
35	Special Cost Centers	859,567	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)*	\$ 10,685,535	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,302,238)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,302,238)	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 Health Care & Rehabilitation Centre

0044818

Report Period Beginning: 1-Jan-2007

Ending: 31-Dec-2007

31-Dec-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	1,933	2,294	\$ 102,519	\$ 44.69	1
2	Assistant Director of Nursing	1,811	2,198	88,372	40.21	2
3	Registered Nurses	50,513	53,032	1,386,785	26.15	3
4	Licensed Practical Nurses	4,436	4,721	106,461	22.55	4
5	CNAs & Orderlies	116,659	124,568	1,452,430	11.66	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,285	1,485	21,830	14.70	9
10	Activity Assistants	30,216	32,363	369,035	11.40	10
11	Social Service Workers	7,184	7,936	114,291	14.40	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	39,582	42,246	417,278	9.88	15
16	Dishwashers					16
17	Maintenance Workers	5,596	6,128	92,214	15.05	17
18	Housekeepers	33,655	36,059	347,264	9.63	18
19	Laundry	10,443	11,310	102,620	9.07	19
20	Administrator	1,845	2,086	97,544	46.76	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,735	10,709	184,909	17.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,719	3,016	43,865	14.54	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	317,612	340,151	\$ 4,927,417 *	\$ 14.49	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	380	\$ 12,586	1-3	35
36	Medical Director	345	18,900	9-3	36
37	Medical Records Consultant	110	4,224	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	312	10,598	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	145	4,325	11-3	44
45	Social Service Consultant	36	1,026	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,328	\$ 51,659		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	24	\$ 960	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	24	\$ 960		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	\$ 97,544	Workers' Compensation Insurance	\$ 117,632	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	53,663	Advertising: Employee Recruitment	2,646	
				FICA Taxes	365,051	Health Care Worker Background Check	1,005	
				Employee Health Insurance	151,655	(Indicate # of checks performed <u>67</u>)		
				Employee Meals	16,749	Patient Background Checks	133	
				Illinois Municipal Retirement Fund (IMRF)*		***Licenses and Fees***	1,318	
				Retirement Plan Contributions	35,353	***Dues and Subscriptions***	1,160	
				Misc. Employee Benefits	17,506	***Advertising and Promotions***	25,122	
				Employment Fees	10,247	***Lancaster Allocation***	35,061	
				Holiday Expenses	12,037			
				Lancaster Allocation	20,686	Less: Public Relations Expense	(38,559)	
						Non-allowable advertising	(15,730)	
						Yellow page advertising	(4,690)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 97,544	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 800,579		\$ 10,323		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
Description			Amount	Description	Line #	Amount	G. Schedule of Travel and Seminar**	
Management Fees - Lancaster			\$ 226,800				Description	
							Amount	
							Out-of-State Travel	
							\$	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 226,800				In-State Travel	
							1,195	
C. Professional Services								
Vendor/Payee	Type		Amount				Seminar Expense	
Frost Ruttenberg and Rothblatt	Accounting		\$ 1,365				4,754	
Richard Peelo	Accounting		2,250				***Lancaster Allocation***	
Personnel Planners	Unemployment Tax Consult.		2,224				4,359	
Health Data Systems, Inc.	Data Processing		6,955					
Accu-med Services, Inc.	Data Processing		3,840				Entertainment Expense	
Stone, Pogrund & Korey	Legal		53,657				(964)	
Myers, Miller & Krauskopf	Legal		37,923					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 108,214	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 9,344	

* 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 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	Painting & Decorating	5/2003	\$ 5,700	3	\$ 1,900	\$ 1,900	\$ 950	\$	\$	\$	\$	\$	\$
2	Painting & Decorating	6/2003	2,050	3	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	Painting & Decorating	6/2007	1,260	3				210	420	420	210		
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 23,420		\$ 3,498	\$ 4,825	\$ 5,022	\$ 4,099	\$ 2,980	\$ 1,494	\$ 210	\$	\$

