

Facility Name & ID Number DEERBROOK CARE CENTRE

0040741 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	78,324	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	78,324	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	9,053	882	8,702	18,637	8
9	SNF/PED					9
10	ICF	35,404	3,447	4,525	43,376	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,457	4,329	13,227	62,013	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.17%

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 7,545

Medicare Intermediary WPS (WISCONSIN PHYSICIAN SERVICES)

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number **DEERBROOK CARE CENTRE** # **0040741** Report Period Beginning: **01/01/2008** Ending: **12/31/2008**

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	316,652	19,663	16,765	353,080		353,080	(991)	352,089		1
2	Food Purchase		278,260		278,260		278,260	(1,615)	276,645		2
3	Housekeeping	223,614	32,678		256,292		256,292	670	256,962		3
4	Laundry	81,000	24,111	1,283	106,394		106,394	(738)	105,656		4
5	Heat and Other Utilities			211,419	211,419		211,419		211,419		5
6	Maintenance	112,326	24,040	38,049	174,415		174,415	(7,854)	166,561		6
7	Other (specify):*			22,200	22,200		22,200		22,200		7
8	TOTAL General Services	733,592	378,752	289,716	1,402,060		1,402,060	(10,528)	1,391,532		8
	B. Health Care and Programs										
9	Medical Director			20,000	20,000		20,000		20,000		9
10	Nursing and Medical Records	2,964,165	247,357	156,807	3,368,329		3,368,329	(30,616)	3,337,713		10
10a	Therapy			2,237	2,237		2,237		2,237		10a
11	Activities	201,310	14,647		215,957		215,957	1,068	217,025		11
12	Social Services			876	876		876		876		12
13	CNA Training										13
14	Program Transportation			66	66		66		66		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,165,475	262,004	179,986	3,607,465		3,607,465	(29,548)	3,577,917		16
	C. General Administration										
17	Administrative	152,376		870,095	1,022,471		1,022,471	(212,075)	810,396		17
18	Directors Fees										18
19	Professional Services			479,865	479,865		479,865	(869,735)	(389,870)		19
20	Dues, Fees, Subscriptions & Promotions			153,090	153,090		153,090	(121,713)	31,377		20
21	Clerical & General Office Expenses	476,591	40,741	54,495	571,827		571,827	199,820	771,647		21
22	Employee Benefits & Payroll Taxes			729,473	729,473		729,473		729,473		22
23	Inservice Training & Education			7,497	7,497		7,497		7,497		23
24	Travel and Seminar			254	254		254	14,728	14,982		24
25	Other Admin. Staff Transportation			3,892	3,892		3,892		3,892		25
26	Insurance-Prop.Liab.Malpractice			133,725	133,725		133,725	20,159	153,884		26
27	Other (specify):*			534,541	534,541		534,541	(534,541)			27
28	TOTAL General Administration	628,967	40,741	2,966,927	3,636,635		3,636,635	(1,503,357)	2,133,278		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,528,034	681,497	3,436,629	8,646,160		8,646,160	(1,543,433)	7,102,727		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
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	13,781
	REPAIRS & MAINTENANCE	2,984
		0
		16,765
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,283
		0
		1,283
5	HEAT & OTHER UTILITIES	
	GAS HEAT	43,582
	ELECTRICITY	116,310
	WATER	49,601
	CABLE TV - LOBBY	1,926
		0
		211,419
6	MAINTENANCE	
	GROUNDS MAINTENANCE	5,953
	PAINTING & DECORATING	6,061
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	6,829
	ELEVATOR MAINTENANCE & REPAIR	10,949
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,575
	FIRE SERVICE	3,682
		0
		0
		0
		0
		38,049
7	OTHER	
	SCAVENGER	22,200
	SECURITY SERVICE	0
		0
		0
		22,200
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	20,000
		20,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,527
	PHARMACY CONSULTANT XVIII B 39-2	21,770
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	123,431
	PSYCHOLOGIST XVIII B 46-2	9,369
	ALZHEIMERS XVIII B 47-2	710
		156,807
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	2,237
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		2,237
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	876
		0
		876
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	66
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	870,095
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	28,083
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	451,782
		0
		479,865
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	81,267
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	26,969
	EMPLOYEE WANT ADS XIX F	14,680
	CONTRIBUTIONS VI 20 XIX F	1,456
	DUES & SUBSCRIPTIONS XIX F	9,874
	LICENSES & PERMITS XIX F	1,861
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	4,064
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	9,209
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,260
	PATIENT BACKGROUND CHECKS XIX F	2,450
		153,090
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	2,491
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	7,827
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	38,527
	MESSENGER SERVICE	5,650
		0
		54,495

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	341,418
	UNEMPLOYMENT COMPENSATION XIX D	55,225
	WORKERS COMPENSATION INSURANC XIX D	92,576
	HOSPITALIZATION INSURANCE XIX D	210,230
	EMPLOYEE BENEFITS - OTHER XIX D	10,505
	EMPLOYEE PHYSICAL EXAMS XIX D	4,491
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	15,028
	CHICAGO HEAD TAX XIX D	0
		0
		729,473
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	7,497
		7,497
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	254
		254
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	3,892
		3,892
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	133,725
		133,725
27	OTHER	
	BAD DEBTS VI 24	534,541
		534,541

GRAND TOTAL COLUMN 3 OTHER

3,436,629

**DEERBROOK CARE CENTRE
SCHEDULES
12/31/2008**

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

TOTAL FOOD PURCHASE	278,260
LESS SALES TAX	<u>(1,615)</u>
NET FOOD	276,645

TOTAL PATIENT CENSUS	62,013
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	186,039

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	186,039
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	186,039

NET FOOD	276,645
DIVIDE TOTAL MEALS/YEAR	<u>186,039</u>

COST PER MEAL	1.49
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

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Facility Name & ID Number

DEERBROOK CARE CENTRE

#0040741

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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			57,704	57,704		57,704	217,640	275,344			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							118,699	118,699			32
33	Real Estate Taxes			88,202	88,202		88,202		88,202			33
34	Rent-Facility & Grounds			792,050	792,050		792,050	(750,020)	42,030			34
35	Rent-Equipment & Vehicles			43,262	43,262		43,262	11,739	55,001			35
36	Other (specify):* STORAGE/MTG INS.			2,175	2,175		2,175	22,719	24,894			36
37	TOTAL Ownership			983,393	983,393		983,393	(379,223)	604,170			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		443,950	766,456	1,210,406		1,210,406		1,210,406			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			117,486	117,486		117,486		117,486			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		443,950	883,942	1,327,892		1,327,892		1,327,892			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,528,034	1,125,447	5,303,964	10,957,445		10,957,445	(1,922,656)	9,034,789			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	1,643	30		9
10	Interest and Other Investment Income	(165,268)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,615)	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	(7,827)	21		18
19	Entertainment	(81,267)	20		19
20	Contributions	(10,665)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(7,874)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(534,541)	27		24
25	Fund Raising, Advertising and Promotional	(26,969)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,064)	20		28
29	Other-Attach Schedule	(6,865)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (845,312)		\$	30

BHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,077,344)	PG 6-6D	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,077,344)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,922,656)		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.		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

DEERBROOK CARE CENTRE

ID# 0040741

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ (4,923)	6	1
2	VACATION ACCRUAL	(991)	1	2
3	VACATION ACCRUAL	670	3	3
4	VACATION ACCRUAL	(738)	4	4
5	VACATION ACCRUAL	(2,931)	6	5
6	VACATION ACCRUAL	4,193	10	6
7	VACATION ACCRUAL	1,068	11	7
8	VACATION ACCRUAL	5,448	17	8
9	VACATION ACCRUAL	(424)	21	9
10	MEDICARE A CONSULTANT	(2,000)	19	10
11	MEDICARE B BILLING		19	11
12	MEDICARE A BILLING	(497)	19	12
13	MARKETING CONSULTANT	(5,740)	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	Total	(6,865)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DEERBROOK CARE CENTRE

0040741

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	(991)	0	0	0	0	0	0	0	0	0	0	(991)	1
2	Food Purchase	(1,615)	0	0	0	0	0	0	0	0	0	0	(1,615)	2
3	Housekeeping	670	0	0	0	0	0	0	0	0	0	0	670	3
4	Laundry	(738)	0	0	0	0	0	0	0	0	0	0	(738)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(7,854)	0	0	0	0	0	0	0	0	0	0	(7,854)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(10,528)	0	0	0	0	0	0	0	0	0	0	(10,528)	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	4,193	0	0	(34,809)	0	0	0	0	0	0	0	(30,616)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	1,068	0	0	0	0	0	0	0	0	0	0	1,068	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	5,261	0	0	(34,809)	0	0	0	0	0	0	0	(29,548)	16
	C. General Administration													
17	Administrative	5,448	0	0	0	0	(217,523)	0	0	0	0	0	(212,075)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(16,111)	13,174	(577,858)	84	(289,024)	0	0	0	0	0	0	(869,735)	19
20	Fees, Subscriptions & Promotions	(122,965)	100	569	174	409	0	0	0	0	0	0	(121,713)	20
21	Clerical & General Office Expenses	(8,251)	0	17,394	3,057	187,620	0	0	0	0	0	0	199,820	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	5,111	4,454	5,163	0	0	0	0	0	0	14,728	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	1,805	2,316	16,038	0	0	0	0	0	0	20,159	26
27	Other (specify):*	(534,541)	0	0	0	0	0	0	0	0	0	0	(534,541)	27
28	TOTAL General Administration	(676,420)	13,274	(552,979)	10,085	(79,794)	(217,523)	0	0	0	0	0	(1,503,357)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(681,687)	13,274	(552,979)	(24,724)	(79,794)	(217,523)	0	0	0	0	0	(1,543,433)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DEERBROOK CARE CENTRE# 0040741

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	1,643	210,727	524	215	4,531	0	0	0	0	0	0	217,640	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(165,268)	283,967	0	0	0	0	0	0	0	0	0	118,699	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	0	42,030	0	0	0	0	0	0	(750,020)	34
35	Rent-Equipment & Vehicles	0	0	6,213	3,712	1,814	0	0	0	0	0	0	11,739	35
36	Other (specify):*	0	22,719	0	0	0	0	0	0	0	0	0	22,719	36
37	TOTAL Ownership	(163,625)	(274,637)	6,737	3,927	48,375	0	0	0	0	0	0	(379,223)	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)	(845,312)	(261,363)	(546,242)	(20,797)	(31,419)	(217,523)	0	0	0	0	0	(1,922,656)	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
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		"		22,719	22,719	2
3	V	30 DEPRECIATION - BLDG IMP		"		210,335	210,335	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		"		245,511	245,511	6
7	V	32 INTEREST - OTHER		"		37,200	37,200	7
8	V	19 ACCOUNTING		"		12,029	12,029	8
9	V	19 DATA PROCESSING		"		194	194	9
10	V	20 LICENSES & PERMITS		"		100	100	10
11	V	19 LEGAL FEES		"		867	867	11
12	V	19 OTHER PROFESSIONAL		"		84	84	12
13	V							13
14	Total		\$ 792,050			\$ 530,687	\$ * (261,363)	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	\$ 652,572	WITTINGHAM MANAGEMENT ASSOCIATES, LLC		\$ 74,714	\$ (577,858)
16	V	20 DUES & SUBSCRIPTIONS		"		569	569
17	V	21 CLERICAL		"		17,394	17,394
18	V	24 TRAVEL		"		5,111	5,111
19	V	26 INSURANCE		"		1,805	1,805
20	V	35 RENT - EQPT & VEH		"		6,213	6,213
21	V	17 ADMINISTRATIVE		"			
22	V	30 DEPRECIATION		"		524	524
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		\$ 652,572			\$ 106,330	\$ * (546,242)

* 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		\$ 88,622	\$ (34,809)
16	V	19 PROFESSIONAL FEES		"		84	84
17	V	20 DUES & SUBSCRIPTIONS		"		174	174
18	V	21 CLERICAL		"		3,057	3,057
19	V	24 TRAVEL		"		4,454	4,454
20	V	26 INSURANCE		"		2,316	2,316
21	V	30 DEPRECIATION		"		215	215
22	V	34 RENT		"			
23	V	35 RENT - EQPT & VEH		"		3,712	3,712
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			\$ 102,634	\$ * (20,797)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 PROFESSIONAL FEES	\$ 304,587	THE KENSINGTON GROUP, LLC		\$ 15,563	\$ (289,024)
16	V	20 DUES & SUBSCRIPTIONS		"		409	409
17	V	21 CLERICAL		"		187,620	187,620
18	V	24 TRAVEL		"		5,163	5,163
19	V	26 INSURANCE		"		16,038	16,038
20	V	30 DEPRECIATION		"		4,531	4,531
21	V	34 RENT		"		42,030	42,030
22	V	35 RENT - EQPT & VEH		"		1,814	1,814
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		\$ 304,587			\$ 273,168	\$ * (31,419)

* 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	\$ 217,523	CHESTERFIELD, LLC		\$	\$ (217,523)
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	Total		\$ 217,523			\$ 0	\$ * (217,523)

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

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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: **01/01/2008**

Ending: **2/31/2008**

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization 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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	358,373	7	\$ 431,773	\$ 62,013	\$ 74,714	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	358,373	7	3,289	62,013	569	2
3	21	CLERICAL	PATIENT DAYS	358,373	7	100,522	62,013	17,394	3
4	24	TRAVEL	PATIENT DAYS	358,373	7	29,536	62,013	5,111	4
5	26	INSURANCE	PATIENT DAYS	358,373	7	10,431	62,013	1,805	5
6	35	RENT - EQPT & VEHICLES	PATIENT DAYS	358,373	7	35,906	62,013	6,213	6
7	30	DEPRECIATION	PATIENT DAYS	358,373	7	3,027	62,013	524	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					\$ 614,484	\$	\$ 106,330	25

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

0040741 Report Period Beginning: **01/01/2008**

Ending: **2/31/2008**

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1 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	10	NURSING	DIRECT HOURS	1	\$ 88,622	\$ 88,622	1	\$ 88,622	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	554,294	11	744	62,013	84	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	554,294	11	1,552	62,013	174	3
4	21	CLERICAL	PATIENT DAYS	554,294	11	27,317	62,013	3,057	4
5	24	TRAVEL	PATIENT DAYS	554,294	11	39,814	62,013	4,454	5
6	26	INSURANCE	PATIENT DAYS	554,294	11	20,700	62,013	2,316	6
7	30	DEPRECIATION	PATIENT DAYS	554,294	11	1,923	62,013	215	7
8	34	RENT	PATIENT DAYS	554,294	11		62,013		8
9	35	RENT - EQPT & VEH	PATIENT DAYS	554,294	11	33,179	62,013	3,712	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				\$ 213,851	\$ 88,622		\$ 102,634	25

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

0040741 Report Period Beginning: **01/01/2008** Ending: **2/31/2008**

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	554,294	11	\$ 139,104	\$ 62,013	\$ 15,563	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	554,294	11	3,659	62,013	409	2
3	21	CLERICAL	PATIENT DAYS	554,294	11	182,061	62,013	20,369	3
4	24	TRAVEL	PATIENT DAYS	554,294	11	46,149	62,013	5,163	4
5	26	INSURANCE	PATIENT DAYS	554,294	11	143,346	62,013	16,038	5
6	30	DEPRECIATION	PATIENT DAYS	554,294	11	40,500	62,013	4,531	6
7	34	RENT	PATIENT DAYS	554,294	11	375,668	62,013	42,030	7
8	35	RENT - EQPT & VEH	PATIENT DAYS	554,294	11	16,218	62,013	1,814	8
9	21	CLERICAL	DIRECT HOURS	1	1	167,251	167,251	1	167,251
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					\$ 1,113,956	\$ 167,251	\$ 273,168	25

Facility Name & ID Number

DEERBROOK CARE CENTRE

0040741

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	RELATED PARTY - DEERBROOK NURSING CENTRE				\$	\$			\$	1										
2	CAPMARK	X	MORTGAGE	\$61,407.35		4,775,900	4,516,829	12/38	5.4000	245,511	2									
3	CAPMARK	X	LOAN COST	AMORT - 35 YEARS		43,959	37,620			1,256	3									
4											4									
5											5									
Working Capital																				
6	LETTER OF CREDIT FEE	X									6									
7	RELATED PARTY	X	WORKING CAPITAL	DEMAND	DEMAND	233,532	412,022	VARIES	VARIES	37,200	7									
8											8									
9	TOTAL Facility Related			\$61,407.35		\$ 5,053,391	\$ 4,966,471			\$ 283,967	9									
B. Non-Facility Related*																				
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	\$ 4,966,471			\$ 283,967	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 2007 report.	\$	90,600	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.)	\$	90,172	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(428)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	91,200	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 \$ <u>2,570</u> For <u>2002 &</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$	(2,570)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	88,202	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	88,433	8
	2004	91,416	9
	2005	91,618	10
	2006	89,650	11
	2007	90,172	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	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 2007 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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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>90,172.26</u>	\$ <u>90,172.26</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>90,172.26</u>	\$ <u>90,172.26</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

01/01/2008 Ending:

12/31/2008

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number DEERBROOK CARE CENTRE

0040741

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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	\$ 29,750		\$ 1,733,053	4
5			1980	168,687		20			168,687	5
6	754 ADJ		1992	125,584	4,567	27.5	4,567		75,161	6
7	754 ADJ.		2001	29,192	1,062	27.5	1,062		8,495	7
8										8
	Improvement Type**									
9	*****RELATED PARTY - DEERBROOK NURSING CENTRE*****									
10	IMPROVEMENTS		1984	33,823		20			33,823	9
11	IMPROVEMENTS		1986	21,535		20			21,535	10
12	IMPROVEMENTS		1987	78,860	2,868	27.5		(2,868)	78,860	11
13	IMPROVEMENTS		1988	48,614	1,768	27.5	1,768		31,755	12
14	IMPROVEMENTS		1989	60,430	2,198	27.5	2,198		38,759	13
15	IMPROVEMENTS		1990	30,485	1,108	27.5	1,108		17,828	14
16	IMPROVEMENTS		1991	53,134	1,932	27.5	1,932		29,898	15
17	IMPROVEMENTS		1992	117,363	4,267	27.5	4,267		61,925	16
18	IMPROVEMENTS		1993	29,335	1,067	27.5	1,067		14,672	17
19	IMPROVEMENTS		1993	29,864	1,085	27.5	1,085		13,035	18
20	IMPROVEMENTS		1994	37,711	1,371	27.5	1,371		19,635	19
21	VINYL SLIDER UNITS		1995	3,070	112	27.5	112		1,507	20
22	DOORS		1995	2,564	93	27.5	93		1,252	21
23	ROOF		1996	24,069	876	27.5	876		10,975	22
24	OUR TOWN		1996	74,400	2,705	27.5	2,705		32,574	23
25	ROOF/REMODEL KITCHEN/DUMPSTER/FLOORS		1997	440,180	16,006	27.5	16,006		182,471	24
26	ALZHEIMERS WING CONSTRUCTION		1997	1,590,575	57,839	27.5	57,839		654,896	25
27	OUR TOWN		1998	21,500	781	27.5	781		8,568	26
28	ALZHEIMERS WING CONSTRUCTION - FINAL DRAW		1998	17,009	619	27.5	619		6,774	27
29	DINING ROOM FLOOR - TILES		1998	30,000	1,091	27.5	1,091		11,956	28
30	DOOR ALARM SYSTEMS		1998	24,760	900	27.5	900		9,864	29
31	SPRINKLERS		1998	3,500	127	27.5	127		1,393	30
32	DINING ROOM - WALLPAPER/TILE BASE		1998	14,900	541	27.5	541		5,893	31
33	RENOVATE 2 ROOMS/REPLACE ELEVATOR FLOORS		1998	9,400	341	27.5	341		3,690	32
34	REMODELING OF ELEVATOR - LOBBY		1998	7,050	256	27.5	256		2,743	33
35	LANDSCAPING		1998	2,815	102	27.5	102		1,094	34
36										35

*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 & ID Number DEERBROOK CARE CENTRE

0040741

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	ROOF TOP PTAC UNITS	1998	\$ 3,508	\$ 128	27.5	\$ 128	\$	\$ 1,369	37
38	DINING & RESIDENT ROOM FLOORS	1998	15,268	556	27.5	556		5,898	38
39	HOT WATER TANK	1998	1,780	65	27.5	65		689	39
40	REMODELING - SHOWER ROOM	1998	3,830	139	27.5	139		1,443	40
41	ASPHALT PARKING LOT & SPEED BUMPS	1998	17,156	624	27.5	624		6,370	41
42	WALLCOVERING/WINDOW TRMETS/TILES	1998	18,635	678	27.5	678		6,920	42
43	REMODELING - RESIDENT ROOMS	1998	37,050	1,347	27.5	1,347		13,526	43
44	WINDOW TREATMENTS/REMODEL RMS	1999	18,066	657	27.5	657		6,543	44
45	FIRE ALARMS & HVAC/CEILING/HALLS/CALL LIGHTS	1999	25,000	909	27.5	909		8,977	45
46	REPAIR & REMODEL HALLWAY/DOOR/MONITOR SYS	1999	23,425	851	27.5	851		8,341	46
47	REMODEL ROOMS/DOOR MONITOR SYS	1999	45,989	1,672	27.5	1,672		16,234	47
48	REMODEL RMS/LANDSCAPING	1999	53,572	1,948	27.5	1,948		18,750	48
49	WALLCOVERING/WINDOW TRMETS/TILES	1999	6,950	253	27.5	253		2,413	49
50	REMODELING RMS	1999	16,205	589	27.5	589		5,572	50
51	WALLCOVERING/FLOOR TILES/HANDRAILS	1999	28,464	1,035	27.5	1,035		9,703	51
52	REMODELING RMS	1999	47,115	1,713	27.5	1,713		15,918	52
53	NURSE STATION/ELEVATOR DOOR	1999	18,030	656	27.5	656		6,040	53
54	REMODELING ROOMS/WINDOW TRMETS	1999	170,712	6,207	27.5	6,207		56,123	54
55	FIRE DAMPERS	2000	4,950	180	27.5	180		1,613	55
56	REMODELING - WASHROOMS/MEDICAL & REC. RM	2000	35,550	1,293	27.5	1,293		11,366	56
57	FENCES	2000	3,557	129	27.5	129		1,125	57
58	WALLCOVERING/WINDOW TRMT - RES & DINING RMS	2000	69,939	2,544	27.5	2,544		21,723	58
59	FIREWALL/RESIDENT ROOM CEILINGS/TUCKPOINTING	2000	85,160	3,096	27.5	3,096		26,447	59
60	MAGNETIC DOOR/STEAMER	2000	16,334	451	27.5	451		3,931	60
61	HANDRAILS	2000	8,101	295	27.5	295		2,494	61
62	REMODELING - NURSE STATION/CORRIDOR/DINING RM	2000	126,731	4,608	27.5	4,608		38,978	62
63	PTAC UNITS	2000	3,550	129	27.5	129		1,091	63
64	CONCRETE PAVING	2000	11,700	425	27.5	425		3,596	64
65	IRRIGATION SYSTEM & ROOM PLATES	2000	10,425	379	27.5	379		3,174	65
66	DESIGN & BUILD ENABLING GARDEN	2000	19,832	1,322	15	1,322		11,242	66
67	CARPETING/WINDOW TREATMENT	2000	14,549	529	27.5	529		4,386	67
68	PTAC UNITS	2000	3,550	129	27.5	129		1,070	68
69	REMODELING - BREAK ROOM & MEDICATION ROOM	2000	39,886	1,450	27.5	1,450		12,024	69
70	TOTAL (lines 4 thru 69)		\$ 5,984,682	\$ 172,418		\$ 169,550	\$ (2,868)	\$ 3,617,860	70

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

Facility Name & ID Number DEERBROOK CARE CENTRE

0040741

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

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	Totals from Page 12A, Carried Forward		\$ 5,984,682	\$ 172,418		\$ 169,550	\$ (2,868)	\$ 3,617,860	1
2	SIDEWALK	2000	2,240	81	27.5	81		666	2
3	REMODELING - RESIDENT RMS, LOBBY, MAILROOM	2000	60,826	2,212	27.5	2,212		18,157	3
4	PTAC UNITS	2000	4,644	169	27.5	169		1,387	4
5	WOOD BLINDS FOR OFFICES	2001	3,538	129	27.5	129		1,025	5
6	CUBICLES	2001	8,332	303	27.5	303		2,411	6
7	REMODEL - ALL 2ND FLOOR RESIDENT ROOMS	2001	370,353	13,468	27.5	13,468		107,172	7
8	VERTICAL BLINDS FOR 2ND FLOOR ROOMS	2001	3,847	140	27.5	140		1,114	8
9	CARPETING FIRST FLOOR OFFICES/PLUMBING	2001	8,850	321	27.5	321		2,508	9
10	DROP & CHANGE SPRINKLER HEADS IN CORRIDOR	2001	5,097	185	27.5	185		1,427	10
11	REPAIR CEILING ON FIRST FLOOR	2001	25,000	909	27.5	909		7,007	11
12	REPAIR CORRIDOR IN LAUNDRY AREA	2001	10,000	364	27.5	364		2,744	12
13	TEN TON COMPRESSOR FOR KITCHEN UNIT	2001	4,441	161	27.5	161		1,175	13
14	INSTALL TILE FLOORING IN SERVICE HALLWAY	2002	11,300	411	27.5	411		2,860	14
15	INSTALL ELECTRICAL OUTLETS IN RMS 101 TO 104	2002	8,000	291	27.5	291		1,904	15
16	INSTALL PIPE RUN FR. ELECTRICAL CLOSET TO RM 104	2002	1,186	43	27.5	43		281	16
17	FRIEDRICH 11700 BTU PTAC UNITS - 2	2002	1,337	49	27.5	49		319	17
18	AMANA - PTAC 12000 BTU HEAT & 11700 PTAC UNIT	2002	1,379	50	27.5	50		323	18
19	REPLACE FIRE PANEL	2003	4,500	164	27.5	164		922	19
20	2 CANVAS AWNINGS	2003	1,650	110	15	110		564	20
21	RESTRIP AND ASPHALT SEAL PARKING LOT	2003	6,535	436	15	436		2,233	21
22	INSTALLATION OF 4 BATHRM WATER SHUT OFF VALVES	2004	2,360	85	27.5	85		425	22
23	WIRING AND INSTALLATION OF TV'S IN RES. ROOMS	2004	20,700	753	27.5	753		3,482	23
24	CONCRETE WORK DONE TO B WING SIDE WALK	2004	5,540	201	27.5	201		914	24
25	REPAIR/REPLACEMENT OF ELECTRICAL LIGHTING	2004	7,350	267	27.5	267		1,214	25
26	INSTALL 80 SOLID CORE, FIRE RATED DOORS	2004	75,115	2,731	27.5	2,731		11,722	26
27	INSTALL NEW ELECTRICAL WIRING & PIPING - 1ST FLR	2004	33,552	1,220	27.5	1,220		4,931	27
28	INSTALLATION OF 20 AMP CIRCUIT IN STORAGE CLOSET	2005	822	30	27.5	30		116	28
29	REMOVED OLD & INSTALLED NEW WATER RECOND. SYS	2005	8,360	304	27.5	304		936	29
30	FIRE SPRINKLER SYSTEM	2005	2,060	75	27.5	75		253	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	355	27.5	355		1,196	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,693,336	\$ 198,435		\$ 195,567	\$ (2,868)	\$ 3,799,248	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	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	Totals from Page 12B, Carried Forward		\$ 6,693,336	\$ 198,435		\$ 195,567	\$ (2,868)	\$ 3,799,248	1
2	DEMOLITION & REMODEL 4 SHOWER ROOMS	2006	321,289	11,683	27.5	11,683		31,642	2
3	DOORS & ALUMINUM DOOR FRAMES	2006	2,150	78	27.5	78		225	3
4	NURSE CALL SYSTEM	2006	4,791	174	27.5	174		385	4
5	NEW PLANTINGS, HEAVY MULCH, PULVERIZED BLACK I	2008	11,513	704	15	704		704	5
6	DESIGN TIME - LOBBY, MEDIA CENTER WINDOW TREAT	2008	11,482	139	27.5	139		139	6
7	PURCHASE OF WALL PAPER	2008	50,337	1,220	27.5	1,220		1,220	7
8	SPRINKLER SYSTEM	2008	4,430	67	27.5	67		67	8
9	DIG & INSTALL CLEAN OUT PLUG - SOUTH WING	2008	3,500	11	27.5	11		11	9
10	WALL PAPER & CARPET-NURSING STATION, PHYSICAL T	2008	54,165	328	27.5	328		328	10
11	DRYWALL & PAINT - THERAPY ROOM, 40 BATHROOMS	2008	60,000	364	27.5	364		364	11
12									12
13									13
14			ADJ. TO SL	(2,868)			2,868		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	TOTAL (lines 1 thru 33)		\$ 7,216,993	\$ 210,335		\$ 210,335	\$	\$ 3,834,333	34

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

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

0040741

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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	\$ 600,969	\$ 32,452	\$ 56,702	\$ 24,250		\$ 410,195	71
72	Current Year Purchases	38,158	22,895	1,908	(20,987)		1,908	72
73	Fully Depreciated Assets	188,666					188,666	73
74	RELATED PARTY		5,662	5,662				74
75	TOTALS	\$ 827,793	\$ 61,009	\$ 64,272	\$ 3,263		\$ 600,769	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	\$ 2,357	\$ 737	\$ (1,620)	10	\$ 1,474	76
77										77
78										78
79										79
80	TOTALS			\$ 7,368	\$ 2,357	\$ 737	\$ (1,620)		\$ 1,474	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,092,874	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 273,701	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 275,344	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,643	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,436,576	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	TOTAL				\$			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: \$ **36,264** 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	2008 TOYOTA CORROL	\$ 300.00	\$ 1,418	17
18	ADMINISTRATIVE	2007 HONDA ACCORD	465.00	5,580	18
19					19
20					20
21	TOTAL		\$ 765.00	\$ 6,998	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. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

* 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>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</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	\$		\$ 318,569	\$		\$ 318,569	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			155,312			155,312	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			292,575			292,575	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				334,049		334,049	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	X-RAY, LAB, I.V. THERAPY Other (specify): RENTAL	39-2					109,901		109,901	13
14	TOTAL			\$		\$ 766,456	\$ 443,950		\$ 1,210,406	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 DEERBROOK CARE CENTRE

0040741

Report Period Beginning: 01/01/2008

Ending:

12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,421,154	\$ 1,857,130	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>552,983</u>)	2,642,691	2,642,691	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	52,110	132,645	6
7	Other Prepaid Expenses	133,206	133,206	7
8	Accounts Receivable (owners or related parties)	22,008	50,008	8
9	Other(specify): <u>ESCROW DEPOSITS</u>		517,563	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,271,169	\$ 5,333,243	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	1,597,567	1,660,051	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		5,208,599	15
16	Equipment, at Historical Cost	835,160	835,160	16
17	Accumulated Depreciation (book methods)	(773,792)	(4,477,797)	17
18	Deferred Charges		151,724	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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,660,890	\$ 5,476,896	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,932,059	\$ 10,810,139	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 890,770	\$ 1,076,641	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	380,606	380,606	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	153,365	153,365	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,604	20,604	31
32	Accrued Real Estate Taxes(Sch.IX-B)		91,200	32
33	Accrued Interest Payable		20,326	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>DUE TO LESSOR</u>	1,739,377		36
37	<u>MANAGEMENT FEES</u>	169,286	169,286	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,354,008	\$ 1,912,028	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		412,022	39
40	Mortgage Payable		4,516,829	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)	\$	\$ 4,928,851	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,354,008	\$ 6,840,879	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,578,051	\$ 3,969,260	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,932,059	\$ 10,810,139	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,364,777	1
2	Restatements (describe):		2
3	NET REPLACEMENT TAX REFUND	(52)	3
4	SEC. 754 ADJ.	454	4
5	ROUNDING ADJ.	(5)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,365,174	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(37,123)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(750,000)	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)	\$ (787,123)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,578,051	24 *

* 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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 10,754,614	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,754,614	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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		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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	165,268	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 165,268	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	NET VENDING COMMISSIONS	440	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 440	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,920,322	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,402,060	31
32	Health Care	3,607,465	32
33	General Administration	3,636,635	33
	B. Capital Expense		
34	Ownership	983,393	34
	C. Ancillary Expense		
35	Special Cost Centers	1,210,406	35
36	Provider Participation Fee	117,486	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,957,445	40
41	Income before Income Taxes (line 30 minus line 40)**	(37,123)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (37,123)	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: 01/01/2008

Ending: 12/31/2008

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	1,859	2,334	\$ 91,949	\$ 39.40	1
2	Assistant Director of Nursing	1,883	2,213	76,982	34.79	2
3	Registered Nurses	33,536	35,908	1,023,695	28.51	3
4	Licensed Practical Nurses	30,207	32,384	709,297	21.90	4
5	CNAs & Orderlies	96,956	101,642	1,028,639	10.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	6,068	6,819	150,471	22.07	9
10	Activity Assistants	6,434	6,630	50,839	7.67	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	3,678	4,192	85,568	20.41	13
14	Head Cook	4,625	4,842	56,516	11.67	14
15	Cook Helpers/Assistants	20,815	21,870	174,568	7.98	15
16	Dishwashers					16
17	Maintenance Workers	7,526	8,364	112,326	13.43	17
18	Housekeepers	19,486	20,543	223,614	10.89	18
19	Laundry	10,160	10,532	81,000	7.69	19
20	Administrator	2,092	2,487	109,562	44.05	20
21	Assistant Administrator	1,204	1,379	42,814	31.05	21
22	Other Administrative					22
23	Office Manager	1,824	2,099	64,607	30.78	23
24	Clerical	21,940	24,152	411,984	17.06	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	1,995	2,182	33,603	15.40	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	272,288	290,572	\$ 4,528,034 *	\$ 15.58	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	\$ 13,781	1-3	35
36	Medical Director	200	20,000	9-3	36
37	Medical Records Consultant	20	1,527	10-3	37
38	Nurse Consultant	1,460	123,431	10-3	38
39	Pharmacist Consultant	289	21,770	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant	31	2,237	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	15	876	12-3	45
46	Other(specify) <u>PSYCHOLOGIST</u>	151	9,369	10-3	46
47	<u>ALZHEIMERS</u>	15	710	10-3	47
48					48
49	TOTAL (lines 35 - 48)	2,389	\$ 193,701		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								
																	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1	PAINT/DECORATING	06/2005	\$ 3,753	3	\$ 626	\$ 1,251	\$ 1,251	\$ 625																	
2	PAINT/DECORATING	06/2006	1,539	3		257	513	513	256																
3																									
4																									
5																									
6																									
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17																									
18																									
19																									
20	TOTALS		\$ 5,292		\$ 626	\$ 1,508	\$ 1,764	\$ 1,138	\$ 256																

Facility Name & ID Number DEERBROOK CARE CENTRE

0040741

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

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. ILL COUNCIL ON LTC - \$16961
- (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. \$ 14,575 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. \$ 117,486
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