



Facility Name & ID Number Elmbrook Health Care & Rehab Centre# 0044818 Report Period Beginning: 1-Jan-2008 Ending: 31-Dec-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	<u>117</u>	Skilled (SNF)	<u>117</u>	<u>42,822</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>63</u>	Intermediate (ICF)	<u>63</u>	<u>23,058</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>65,880</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>25,985</u>	<u>3,597</u>	<u>7,696</u>	<u>37,278</u>	8
9	SNF/PED					9
10	ICF	<u>17,884</u>	<u>2,166</u>	<u>38</u>	<u>20,088</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>43,869</u>	<u>5,763</u>	<u>7,734</u>	<u>57,366</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.08%

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 &amp; 4 include expenses for services or investments not directly related to patient care?

YES  NO 

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO 

I. On what date did you start providing long term care at this location?

Date started 18th April, 2000

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

YES  Date 18th April 2000 NO 

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

YES  NO  If YES, enter number of beds certified 117 and days of care provided 6,771Medicare Intermediary National Government Services

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 31st Dec 2008 Fiscal Year: 31st Dec 2008

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

Facility Name & ID Number Elmbrook Health Care & Rehab Centre # 0044818 Report Period Beginning: 1-Jan-2008 Ending: 31-Dec-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
	<b>A. General Services</b>										
1	Dietary	385,535	74,278	31,545	491,358		491,358		491,358		1
2	Food Purchase		391,642		391,642	(17,644)	373,998	(365)	373,633		2
3	Housekeeping	338,996	73,907		412,903		412,903		412,903		3
4	Laundry	109,515	68,055		177,570		177,570		177,570		4
5	Heat and Other Utilities			353,650	353,650		353,650		353,650		5
6	Maintenance	94,538	54,625	100,366	249,529		249,529	6,217	255,746		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	928,584	662,507	485,561	2,076,652	(17,644)	2,059,008	5,852	2,064,860		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			20,400	20,400		20,400		20,400		9
10	Nursing and Medical Records	3,324,964	362,056	6,020	3,693,040		3,693,040		3,693,040		10
10a	Therapy		7,396	9,531	16,927		16,927		16,927		10a
11	Activities	350,399	35,935	6,431	392,765		392,765		392,765		11
12	Social Services	106,985		825	107,810		107,810		107,810		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>*Dental Service**</b>			110	110		110		110		15
16	<b>TOTAL Health Care and Programs</b>	3,782,348	405,387	43,317	4,231,052		4,231,052		4,231,052		16
	<b>C. General Administration</b>										
17	Administrative	98,795		226,800	325,595		325,595	(114,146)	211,449		17
18	Directors Fees										18
19	Professional Services			122,092	122,092		122,092	5,819	127,911		19
20	Dues, Fees, Subscriptions & Promotions			32,625	32,625		32,625	(13,623)	19,002		20
21	Clerical & General Office Expenses	182,888	52,800	162,703	398,391		398,391	(31,557)	366,834		21
22	Employee Benefits & Payroll Taxes			752,832	752,832	17,644	770,476	15,834	786,310		22
23	Inservice Training & Education			3,035	3,035		3,035	216	3,251		23
24	Travel and Seminar			6,997	6,997		6,997	431	7,428		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			104,203	104,203		104,203		104,203		26
27	Other (specify):* <b>*Payroll Taxes (Sch VII)</b>							18,742	18,742		27
28	<b>TOTAL General Administration</b>	281,683	52,800	1,411,287	1,745,770	17,644	1,763,414	(118,284)	1,645,130		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,992,615	1,120,694	1,940,165	8,053,474		8,053,474	(112,432)	7,941,042		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
	<b>D. Ownership</b>										
30	Depreciation			75,885	75,885	75,885	348,941	424,826			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			144,293	144,293	144,293	665,603	809,896			32
33	Real Estate Taxes			46,788	46,788	46,788		46,788			33
34	Rent-Facility & Grounds			1,500,000	1,500,000	1,500,000	(1,500,000)				34
35	Rent-Equipment & Vehicles			5,603	5,603	5,603		5,603			35
36	Other (specify):* <b>*Amortization of Goodwill*</b>			195,618	195,618	195,618		195,618			36
37	<b>TOTAL Ownership</b>			1,968,187	1,968,187	1,968,187	(485,456)	1,482,731			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		364,625	759,588	1,124,213	1,124,213		1,124,213			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			98,820	98,820	98,820		98,820			42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>		364,625	858,408	1,223,033	1,223,033		1,223,033			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,992,615	1,485,319	4,766,760	11,244,694	11,244,694	(597,888)	10,646,806			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	79,497	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	(365)	2		13
14	Non-Care Related Interest	(104)	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		24		19
20	Contributions	(300)	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	(119,991)	21		24
25	Fund Raising, Advertising and Promotional	(57,996)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,161)	20		28
29	Other-Attach Schedule <b>** Page 5A attached **</b>	1,580	6		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (98,840)		\$	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)	(499,048)	6 & 6A	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (499,048)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)</b>	\$ (597,888)		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					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

BHF USE ONLY					
48		49		50	51
					52

Elmbrook Health Care & Rehab Centre

ID# 0044818

Report Period Beginning: 1-Jan-2008

Ending: 31-Dec-2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Painting & Decorating (incurred in 2008)	\$ (2,100)	6 1
2	Painting & Decorating (allocated for 2008)	3,680	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	<b>Total</b>	1,580	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Elmbrook Health Care &amp; Rehab Centre

# 0044818

Report Period Beginning:

1-Jan-2008

Ending:

31-Dec-2008

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(365)	0	0	0	0	0	0	0	0	0	0	(365)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	1,580	4,637	0	0	0	0	0	0	0	0	0	6,217	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>1,215</b>	<b>4,637</b>	<b>0</b>	<b>5,852</b>	<b>8</b>								
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(114,146)	0	0	0	0	0	0	0	0	0	(114,146)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	5,819	0	0	0	0	0	0	0	0	0	5,819	19
20	Fees, Subscriptions & Promotions	(59,457)	45,834	0	0	0	0	0	0	0	0	0	(13,623)	20
21	Clerical & General Office Expenses	(119,991)	88,434	0	0	0	0	0	0	0	0	0	(31,557)	21
22	Employee Benefits & Payroll Taxes	0	15,834	0	0	0	0	0	0	0	0	0	15,834	22
23	Inservice Training & Education	0	216	0	0	0	0	0	0	0	0	0	216	23
24	Travel and Seminar	0	431	0	0	0	0	0	0	0	0	0	431	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	18,742	0	0	0	0	0	0	0	0	0	18,742	27
28	<b>TOTAL General Administration</b>	<b>(179,448)</b>	<b>61,164</b>	<b>0</b>	<b>(118,284)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(178,233)</b>	<b>65,801</b>	<b>0</b>	<b>(112,432)</b>	<b>29</b>								

STATE OF ILLINOIS

Facility Name & ID Number Elmbrook Health Care & Rehab Centre

# 0044818

Report Period Beginning:

1-Jan-2008 Ending:

Summary B

31-Dec-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	79,497	8,472	260,972	0	0	0	0	0	0	0	0	348,941	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(104)	(86,762)	752,469	0	0	0	0	0	0	0	0	665,603	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	<b>TOTAL Ownership</b>	<b>79,393</b>	<b>(78,290)</b>	<b>(486,559)</b>	<b>0</b>	<b>(485,456)</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(98,840)</b>	<b>(12,489)</b>	<b>(486,559)</b>	<b>0</b>	<b>(597,888)</b>	<b>45</b>							

Facility Name & ID Number Elmbrook Health Care & Rehab Centre

# 0044818

Report Period Beginning: 1-Jan-2008 Ending: 31-Dec-2008

**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%	35,872	35,872	2
3	V	19 Professional Services		Lancaster, Ltd.	100.00%	5,819	5,819	3
4	V	21 Clerical Expenses		Lancaster, Ltd.	100.00%	88,434	88,434	4
5	V	22 Employee Benefits		Lancaster, Ltd.	100.00%	15,834	15,834	5
6	V	24 Seminars & Travel		Lancaster, Ltd.	100.00%	431	431	6
7	V	17 Administrative Consulting		Lancaster, Ltd.	100.00%	76,782	76,782	7
8	V	20 Marketing, Fees & Subscriptions		Lancaster, Ltd.	100.00%	45,834	45,834	8
9	V	30 Depreciation		Lancaster, Ltd.	100.00%	8,472	8,472	9
10	V	27 Payroll Taxes (Staff & Officers)		Lancaster, Ltd.	100.00%	18,742	18,742	10
11	V	23 Education & Inservice		Lancaster, Ltd.	100.00%	216	216	11
12	V	6 Repairs & Maintenance		Lancaster, Ltd.	100.00%	4,637	4,637	12
13	V	32 *Direct Interest*	86,762	Lancaster, Ltd.	100.00%		(86,762)	13
14	Total		\$ 313,562			\$ 301,073	\$ * (12,489)	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	34 Rental	\$ 1,500,000			\$	(1,500,000)	15
16	V	32 Interest	57,531			810,000	752,469	16
17	V	30 Depreciation				260,972	260,972	17
18	V							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		\$ 1,557,531			\$ 1,070,972	\$ * (486,559)	39

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

Facility Name & ID Number Elmbrook Health Care & Rehab Centre # 0044818 Report Period Beginning: 1-Jan-2008 Ending: 31-Dec-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	Christopher Vicere	VP-Finance	Administrative		See attached	5	10.42	Lancaster	\$ 17,936	17-7	1
2	Cheryl Morris	VP-Operations	Administrative		See attached	5	10.42	Lancaster	17,936	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	\$ 35,872		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 Elmbrook Health Care & Rehab Centre

# 0044818

Report Period Beginning:

1-Jan-2008

Ending: -Dec-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 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

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	\$ 172,189	\$ 172,189	5	\$ 17,936	1
2	27	Christopher Vicere-payroll tax	Hours Worked	48	7	9,309		5	970	2
3	17	Cheryl Morris	Hours Worked	48	7	172,189	172,189	5	17,936	3
4	27	Cheryl Morris-payroll tax	Hours Worked	48	7	9,309		5	970	4
5										5
6										6
7										7
8										8
9										9
10	19	Professional Services	Management Fees	1,694,700		43,482		226,800	5,819	10
11	21	Clerical Expenses	Management Fees	1,694,700		660,800	590,769	226,800	88,434	11
12	22	Employee Benefits	Management Fees	1,694,700		118,314		226,800	15,834	12
13	24	Seminars and Travel	Management Fees	1,694,700	7	3,223		226,800	431	13
14	17	Administrative Consulting	Management Fees	1,694,700	7	573,729	573,729	226,800	76,782	14
15	20	Marketing Fees	Management Fees	1,694,700	7	336,332	316,659	226,800	45,011	15
16	30	Depreciation	Management Fees	1,694,700	7	63,305		226,800	8,472	16
17	20	Dues, Fees and Subscriptions	Management Fees	1,694,700	7	6,153		226,800	823	17
18	27	Payroll Taxes	Management Fees	1,694,700	7	125,546		226,800	16,802	18
19	23	Education and Inservice	Management Fees	1,694,700	7	1,615		226,800	216	19
20	6	Repairs and Maintenance	Management Fees	1,694,700	7	34,646		226,800	4,637	20
21	32	*Direct Interest*	Management Fees	1,694,700	7				0	21
22										22
23										23
24										24
25	TOTALS					\$ 2,330,141	\$ 1,825,534		\$ 301,073	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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
<b>Working Capital</b>																				
6	Harston Investments		X	Working Capital					810,000	6										
7										7										
8										8										
9	<b>TOTAL Facility Related</b>					\$	\$		\$ 810,000	9										
<b>B. Non-Facility Related*</b>																				
10										10										
11										11										
12										12										
13										13										
14	<b>TOTAL Non-Facility Related</b>					\$	\$		\$	14										
15	<b>TOTALS (line 9+line14)</b>					\$	\$		\$ 810,000	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 (104)  
809,896  
 Page 4 Line 32 col. 8

\* 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><b>Important</b>, 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 2007 report.		\$ 57,500	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.)		\$ 51,288	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (6,212)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 53,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 46,788	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	45,836	8
	2004	47,519	9
	2005	52,417	10
	2006	54,950	11
	2007	51,288	12
<b>* Accrual for 2008 report is based on 2007 Taxes adjusted for inflation</b>			
<b>FOR BHF USE ONLY</b>			
	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

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 Elmbrook Health Care & Rehab 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 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>03-26-207-022</u>	<u>Long-Term Health Care</u>	\$ <u>4,035.42</u>	\$ <u>4,035.42</u>
2. <u>03-26-207-025</u>	<u>Long-Term Health Care</u>	\$ <u>47,252.42</u>	\$ <u>47,252.42</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>51,287.84</u>	\$ <u>51,287.84</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.

**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	<b>TOTALS</b>	<b>67,000</b>		<b>\$ 565,000</b>	<b>3</b>

**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	\$ 808,275	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9		Front Sign and Awnings		2001	5,750	340	15	340		3,162	9
10		General Construction - Phase I		2001	191,999	4,923	20	4,923		34,666	10
11		Fire Security		2001	9,021	231	20	231		1,627	11
12		Electrical		2001	3,045	78	20	78		549	12
13		Rehab Satellite		2002	86,171	2,209	10	8,617	6,408	52,420	13
14		General Construction - Phase II		2002	538,782	13,814	10	53,878	40,064	327,758	14
15		Faux Wood Blinds		2003	3,502	101	5	292	191	3,296	15
16		New Roof		2003	36,561	937	10	3,656	2,719	18,585	16
17		Upgrade Elevators		2004	34,190	877	20	1,710	833	7,125	17
18		Construction & Design Cost		2004	15,873	407	10	1,588	1,181	7,931	18
19		Elevator Fire Alarm Equipment		2005	9,360	240	10	936	696	3,744	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	<b>TOTAL (lines 4 thru 69)</b>	\$	\$		\$	\$	\$	70
		7,749,986	198,912		251,011	52,099	1,269,138	

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

Facility Name & ID Number Elmbrook Health Care & Rehab Centre # 0044818 Report Period Beginning: 1-Jan-2008 Ending: 31-Dec-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	\$ 931,723	\$ 111,380	\$ 155,672	\$ 44,292		\$ 742,023	71
72	Current Year Purchases	37,856	22,714	6,367	(16,347)		6,367	72
73	Fully Depreciated Assets	204,016	3,851	3,304	(547)		204,016	73
74	**Lancaster Allocation**		8,472	8,472			13,469	74
75	TOTALS	\$ 1,173,595	\$ 146,417	\$ 173,815	\$ 27,398		\$ 965,875	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)	\$ 9,488,581	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 345,329	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 424,826	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 79,497	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,235,013	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	<b>TOTAL</b>				\$ _____			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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 5,603 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	<b>TOTAL</b>		\$ _____	\$ _____	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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 275,712	\$		\$ 275,712	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			85,355			85,355	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			394,841			394,841	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation <b>**Inhalation Therapy**</b>	39-3	hrs			3,680			3,680	8
9	Pharmacy	39-2	# of prescrpts				249,759		249,759	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <b>**Medical Supplies**</b>	39-2					33,625		33,625	12
13	Other (specify): <b>**Speciality Beds**</b>	39-2					81,241		81,241	13
14	TOTAL			\$		\$ 759,588	\$ 364,625		\$ 1,124,213	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 Elmbrook Health Care & Rehab Centre# 0044818Report Period Beginning: 1-Jan-2008

Ending:

31-Dec-2008

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 31-Dec-2008 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 350	\$ 5,350	1
2	Cash-Patient Deposits	36,579	36,579	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	3,807,688	3,807,688	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	50,528	50,528	6
7	Other Prepaid Expenses	5,135	5,135	7
8	Accounts Receivable (owners or related parties)	2,820	2,820	8
9	Other(specify): <b>**Refundable deposit**</b>	2,540	2,540	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 3,905,640	\$ 3,910,640	10
	<b>B. Long-Term Assets</b>			
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	526,215	1,173,596	16
17	Accumulated Depreciation (book methods)	(522,975)	(2,025,444)	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 <b>**Goodwill**</b> )	2,934,268	2,934,268	22
23	Other(specify): <b>**Goodwill Amortization**</b>	(896,582)	(896,582)	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 2,420,526	\$ 9,500,825	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 6,326,166	\$ 13,411,465	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 252,102	\$ 252,102	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	36,579	36,579	28
29	Short-Term Notes Payable	6,260,279	3,854,185	29
30	Accrued Salaries Payable	462,197	462,197	30
31	Accrued Taxes Payable (excluding real estate taxes)	21,294	21,294	31
32	Accrued Real Estate Taxes(Sch.IX-B)	53,000	53,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 7,085,451	\$ 4,679,357	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		8,100,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$ 8,100,000	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 7,085,451	\$ 12,779,357	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (759,285)	\$ 632,108	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 6,326,166	\$ 13,411,465	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,641,423)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,641,423)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(617,862)	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 2,882,138</b>	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ (759,285)</b>	24 *

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

**XVI. STATEMENT OF CHANGES IN EQUITY**

		Total after cosolidation	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,236,589)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,236,589)	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	(131,303)	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)	\$ 4,868,697	17
	<b>B. Transfers (Itemize):</b>		
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)	\$ 632,108	24 *

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

Facility Name & ID Number Elmbrook Health Care & Rehab Centre# 0044818Report Period Beginning: 1-Jan-2008Ending: 31-Dec-2008**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 11,115,836	1
2	Discounts and Allowances for all Levels	(2,411,434)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 8,704,402	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,629,944	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,629,944	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		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	236,586	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,509	19
20	Radiology and X-Ray	9,323	20
21	Other Medical Services	37,964	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 292,382	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	104	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 104	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 10,626,832	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,076,652	31
32	Health Care	4,231,052	32
33	General Administration	1,745,770	33
<b>B. Capital Expense</b>			
34	Ownership	1,968,187	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,124,213	35
36	Provider Participation Fee	98,820	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 11,244,694	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(617,862)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (617,862)	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. \*\*Adjusted Page 5 &amp; 9

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

Facility Name & ID Number Elmbrook Health Care & Rehab Centre

# 0044818

Report Period Beginning:

1-Jan-2008

Ending:

31-Dec-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	1,865	2,131	\$ 96,831	\$ 45.44	1
2	Assistant Director of Nursing	1,857	2,091	87,062	41.64	2
3	Registered Nurses	60,630	65,007	1,615,450	24.85	3
4	Licensed Practical Nurses	3,215	3,677	85,060	23.13	4
5	CNAs & Orderlies	113,747	121,718	1,408,737	11.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,859	2,083	31,905	15.32	9
10	Activity Assistants	25,534	28,170	318,494	11.31	10
11	Social Service Workers	6,787	7,579	106,985	14.12	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	37,884	40,038	385,535	9.63	15
16	Dishwashers					16
17	Maintenance Workers	5,637	6,224	94,538	15.19	17
18	Housekeepers	32,265	34,747	338,996	9.76	18
19	Laundry	11,457	12,266	109,515	8.93	19
20	Administrator	1,878	2,092	98,795	47.23	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,422	12,402	182,888	14.75	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	1,845	2,166	31,824	14.69	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	317,882	342,391	\$ 4,992,615 *	\$ 14.58	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	956	\$ 31,545	1-3	35
36	Medical Director	379	20,400	9-3	36
37	Medical Records Consultant	115	4,320	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	281	9,531	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	215	6,431	11-3	44
45	Social Service Consultant	29	825	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,975	\$ 73,052		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	43	\$ 1,700	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	43	\$ 1,700		53



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 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1	Painting & Decorating	5/2003	\$ 5,700	3	\$ 1,900	\$ 950							
2	Painting & Decorating	6/2003	2,050	3	683	342							
3	Painting & Decorating	2/2004	1,992	3	664	664	332						
4	Painting & Decorating	8/2004	1,528	3	509	509	255						
5	Painting & Decorating	12/2004	1,968	3	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	Painting & Decorating	7/2008	2,100	3				700	700	700			
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 25,520		\$ 4,825	\$ 5,022	\$ 4,099	\$ 3,680	\$ 2,194	\$ 910	\$	\$	\$

