

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

0044818 Report Period Beginning: 1-Jan-2009 Ending: 31-Dec-2009

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	117	Skilled (SNF)	117	42,705	1
2		Skilled Pediatric (SNF/PED)			2
3	63	Intermediate (ICF)	63	22,995	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	180	TOTALS	180	65,700	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	25,767	2,646	7,442	35,855	8
9	SNF/PED					9
10	ICF	19,982	1,734	336	22,052	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	45,749	4,380	7,778	57,907	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.14%

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)

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 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 6,483

Medicare 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 2009 Fiscal Year: 31st Dec 2009

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

Facility Name & ID Number Elm Brook Health Care & Rehabilitation Center # 0044818 Report Period Beginning: 1-Jan-2009 Ending: 31-Dec-2009

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjustments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	412,249	57,272	23,399	492,920		492,920		492,920		1
2	Food Purchase		435,464		435,464	(18,737)	416,727	(295)	416,432		2
3	Housekeeping	411,118	75,887		487,005		487,005		487,005		3
4	Laundry	67,863	66,001		133,864		133,864		133,864		4
5	Heat and Other Utilities			317,472	317,472		317,472		317,472		5
6	Maintenance	94,639	48,919	92,568	236,126		236,126	4,424	240,550		6
7	Other (specify):*										7
8	TOTAL General Services	985,869	683,543	433,439	2,102,851	(18,737)	2,084,114	4,129	2,088,243		8
	B. Health Care and Programs										
9	Medical Director			20,400	20,400		20,400		20,400		9
10	Nursing and Medical Records	3,757,630	395,044	7,200	4,159,874		4,159,874		4,159,874		10
10a	Therapy		8,952	11,975	20,927		20,927		20,927		10a
11	Activities	370,912	38,154	3,430	412,496		412,496		412,496		11
12	Social Services	96,506		4,788	101,294		101,294		101,294		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* *Dental Service**										15
16	TOTAL Health Care and Programs	4,225,048	442,150	47,793	4,714,991		4,714,991		4,714,991		16
	C. General Administration										
17	Administrative	98,569		299,040	397,609		397,609	(172,720)	224,889		17
18	Directors Fees										18
19	Professional Services			77,827	77,827		77,827	5,575	83,402		19
20	Dues, Fees, Subscriptions & Promotions			24,139	24,139		24,139	(13,706)	10,433		20
21	Clerical & General Office Expenses	191,332	70,236	244,348	505,916		505,916	(109,317)	396,599		21
22	Employee Benefits & Payroll Taxes			765,924	765,924	18,737	784,661	10,190	794,851		22
23	Inservice Training & Education			3,485	3,485		3,485	3,341	6,826		23
24	Travel and Seminar			6,309	6,309		6,309	1,442	7,751		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			318,183	318,183		318,183		318,183		26
27	Other (specify):* *Payroll Taxes (Sch VII)							21,783	21,783		27
28	TOTAL General Administration	289,901	70,236	1,739,255	2,099,392	18,737	2,118,129	(253,412)	1,864,717		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,500,818	1,195,929	2,220,487	8,917,234		8,917,234	(249,283)	8,667,951		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.

Facility Name & ID Number Elm Brook Health Care & Rehabilitation Centre #0044818 Report Period Beginning: 1-Jan-2009 Ending: 31-Dec-2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			79,249	79,249		79,249	285,669	364,918			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			63,534	63,534		63,534	754,275	817,809			32
33	Real Estate Taxes			55,581	55,581		55,581		55,581			33
34	Rent-Facility & Grounds			1,500,000	1,500,000		1,500,000	(1,500,000)				34
35	Rent-Equipment & Vehicles			3,998	3,998		3,998		3,998			35
36	Other (specify):* *Amortization of Goodwill*			195,618	195,618		195,618		195,618			36
37	TOTAL Ownership			1,897,980	1,897,980		1,897,980	(460,056)	1,437,924			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		418,980	806,043	1,225,023		1,225,023		1,225,023			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			98,550	98,550		98,550		98,550			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		418,980	904,593	1,323,573		1,323,573		1,323,573			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,500,818	1,614,909	5,023,060	12,138,787		12,138,787	(709,339)	11,429,448			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	55,041	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	(295)	2		13
14	Non-Care Related Interest	(63)	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	(208,858)	21		24
25	Fund Raising, Advertising and Promotional	(70,805)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,702)	20		28
29	Other-Attach Schedule	1,844	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (227,138)		\$	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)	(482,201)	6 & 6A	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (482,201)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (709,339)		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	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY

48		49		50		51		52
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Elm Brook Health Care & Rehabilitation Centre

ID# 0044818

Report Period Beginning: 1-Jan-2009

Ending: 31-Dec-2009

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Painting & Decorating (incurred in 2009)	\$ (525)	6	1
2	Painting & Decorating (allocated for 2009-pg 22)	2,369	6	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	1,844		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elm Brook Health Care & Rehabilitation Centre# 0044818

Report Period Beginning:

1-Jan-2009

Ending:

31-Dec-2009

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(295)	0	0	0	0	0	0	0	0	0	0	(295)	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	1,844	2,580	0	0	0	0	0	0	0	0	0	4,424	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	1,549	2,580	0	0	0	0	0	0	0	0	0	4,129	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(172,720)	0	0	0	0	0	0	0	0	0	(172,720)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,275	1,300	0	0	0	0	0	0	0	0	5,575	19
20	Fees, Subscriptions & Promotions	(74,807)	61,101	0	0	0	0	0	0	0	0	0	(13,706)	20
21	Clerical & General Office Expenses	(208,858)	99,541	0	0	0	0	0	0	0	0	0	(109,317)	21
22	Employee Benefits & Payroll Taxes	0	10,190	0	0	0	0	0	0	0	0	0	10,190	22
23	Inservice Training & Education	0	3,341	0	0	0	0	0	0	0	0	0	3,341	23
24	Travel and Seminar	0	1,442	0	0	0	0	0	0	0	0	0	1,442	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	21,783	0	0	0	0	0	0	0	0	0	21,783	27
28	TOTAL General Administration	(283,665)	28,953	1,300	0	(253,412)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(282,116)	31,533	1,300	0	(249,283)	29							

STATE OF ILLINOIS

Facility Name & ID Number Elm Brook Health Care & Rehabilitation Centre# 0044818

Report Period Beginning:

1-Jan-2009 Ending:

Summary B

31-Dec-2009

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	55,041	3,439	227,189	0	0	0	0	0	0	0	0	285,669	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(63)	(26,658)	780,996	0	0	0	0	0	0	0	0	754,275	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(1,500,000)	0	0	0	0	0	0	0	0	(1,500,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	54,978	(23,219)	(491,815)	0	(460,056)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(227,138)	8,314	(490,515)	0	0	0	0	0	0	0	0	(709,339)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 Management Fee Income	\$ 299,040	Lancaster, Ltd.	100.00%	\$	(299,040)	1
2	V	17 Officers' Salaries		Lancaster, Ltd.	100.00%	35,872	35,872	2
3	V	27 Payroll Taxes-Officers & Staff		Lancaster, Ltd.	100.00%	21,783	21,783	3
4	V	19 Professional Services		Lancaster, Ltd.	100.00%	4,275	4,275	4
5	V	21 Clerical Expenses		Lancaster, Ltd.	100.00%	99,541	99,541	5
6	V	22 Employee Benefits		Lancaster, Ltd.	100.00%	10,190	10,190	6
7	V	24 Seminars & Travel		Lancaster, Ltd.	100.00%	1,442	1,442	7
8	V	17 Administrative Consulting		Lancaster, Ltd.	100.00%	90,448	90,448	8
9	V	20 Dues,Subscriptions & Marketing Fees		Lancaster, Ltd.	100.00%	61,101	61,101	9
10	V	30 Depreciation		Lancaster, Ltd.	100.00%	3,439	3,439	10
11	V	32 Interest-Incl. Direct Interest	34,530	Lancaster, Ltd.	100.00%	7,872	(26,658)	11
12	V	23 Education & Inservice		Lancaster, Ltd.	100.00%	3,341	3,341	12
13	V	6 Repairs & Maintenance		Lancaster, Ltd.	100.00%	2,580	2,580	13
14	Total		\$ 333,570			\$ 341,884	\$ *	8,314 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	Elmhurst Healthcare & Rehab. Centre Associates, LLC.		\$	(1,500,000)
16	V	32 Interest	29,004	Elmhurst Healthcare & Rehab. Centre Associates, LLC.		810,000	780,996
17	V	30 Depreciation		Elmhurst Healthcare & Rehab. Centre Associates, LLC.		227,189	227,189
18	V	19 Professional Fees		Elmhurst Healthcare & Rehab. Centre Associates, LLC.		1,300	1,300
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		\$ 1,529,004			\$ 1,038,489	\$ * (490,515)

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

Facility Name & ID Number Elm Brook Health Care & Rehabilitation Ce # 0044818 Report Period Beginning: 1-Jan-2009 Ending: 31-Dec-2009

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 Elm Brook Health Care & Rehabilitation Centre # 0044818 Report Period Beginning: 1-Jan-2009 Ending: -Dec-2009

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Lancaster, Ltd.
 Street Address 5061 N. Pulaski Road
 City / State / Zip Code Chicago, IL 60630
 Phone Number (773)604-4416
 Fax Number (773)478.1192

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Christopher Vicere	Hours Worked	48	7	\$ 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	19	Professional Services	Management Fees	2,190,720	7	31,315		299,040	4,275	8
9	21	Clerical Expenses	Management Fees	2,190,720	7	729,221	681,138	299,040	99,541	9
10	22	Employee Benefits	Management Fees	2,190,720	7	74,654		299,040	10,190	10
11	24	Seminars and Travel	Management Fees	2,190,720	7	10,564		299,040	1,442	11
12	17	Administrative Consulting	Management Fees	2,190,720	7	662,608	662,608	299,040	90,448	12
13	20	Marketing Fees	Management Fees	2,190,720	7	430,592	417,882	299,040	58,777	13
14	20	Dues, Fees and Subscriptions	Management Fees	2,190,720	7	17,027		299,040	2,324	14
15	30	Depreciation	Management Fees	2,190,720	7	25,194		299,040	3,439	15
16	32	Interest	Management Fees	2,190,720	7	57,668		299,040	7,872	16
17	23	Education & Inservice	Management Fees	2,190,720	7	24,476		299,040	3,341	17
18	6	Repairs and Maintenance	Management Fees	2,190,720	7	18,904		299,040	2,580	18
19	27	Payroll Taxes	Management Fees	2,190,720	7	145,366		299,040	19,843	19
20										20
21	32	*Direct Interest*								21
22										22
23										23
24										24
25	TOTALS					\$ 2,590,585	\$ 2,106,006		\$ 341,884	25

Facility Name & ID Number

Elm Brook Health Care & Rehabilitation Cen

0044818

Report Period Beginning:

1-Jan-2009

Ending:

31-Dec-2009

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										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1										1									
2										2									
3										3									
4										4									
5										5									
Working Capital																			
6	Harston Investments	X	Working Capital						810,000	6									
7	JP Morgan Chase Bank	X	Working Capital						7,872	7									
8										8									
9	TOTAL Facility Related								817,872	9									
B. Non-Facility Related*																			
10										10									
11										11									
12										12									
13										13									
14	TOTAL Non-Facility Related									14									
15	TOTALS (line 9+line14)								817,872	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 (63) 817,809
 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.)

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:

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	180	2004		\$ 6,815,732	\$ 174,755	40	\$ 174,762	\$ 7	\$ 983,037	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Front Sign and Awnings	2001		5,750	340	15	340		3,502	9
10	General Construction - Phase I	2001		191,999	4,923	20	4,923		39,589	10
11	Fire Security	2001		9,021	231	20	231		1,858	11
12	Electrical	2001		3,045	78	20	78		627	12
13	Rehab Satellite	2002		86,171	2,209	10	8,617	6,408	61,037	13
14	General Construction - Phase II	2002		538,782	13,814	10	53,878	40,064	381,636	14
15	Faux Wood Blinds	2003		3,502		5			3,296	15
16	New Roof	2003		36,561	937	10	3,656	2,719	22,241	16
17	Upgrade Elevators	2004		34,190	877	20	1,710	833	8,835	17
18	Construction & Design Cost	2004		15,873	407	10	1,588	1,181	9,519	18
19	Elevator Fire Alarm Equipment	2005		9,360	240	10	936	696	4,680	19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 7,749,986	\$ 198,811		\$ 250,719	\$ 51,908	\$ 1,519,857	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 376,377	\$ 35,148	\$ 62,191	\$ 27,043		\$ 256,788	71
72	Current Year Purchases	65,621	39,373	9,160	(30,213)		9,160	72
73	Fully Depreciated Assets	797,218	33,106	39,409	6,303		797,218	73
74	**Lancaster Allocation**		3,439	3,439			16,908	74
75	TOTALS	\$ 1,239,216	\$ 111,066	\$ 114,199	\$ 3,133		\$ 1,080,074	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)	\$ 9,554,202	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 309,877	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 364,918	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 55,041	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,599,931	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: **Elmhurst Healthcare and Rehabilitation Centre Associates, LLc. (A related Entity)**

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: \$ 3,998 Description: E Cylinder (Oxygen) @\$4 per cylinder per month and @\$2 per half month or part thereof

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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. _____/2010 \$ _____

13. _____/2011 \$ _____

14. _____/2012 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 274,527	\$		\$ 274,527	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			134,343			134,343	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			394,501			394,501	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation **Inhalation Therapy**	39-3	hrs			2,672			2,672	8
9	Pharmacy	39-2	# of prescrpts				235,351		235,351	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): **Medical Supplies**	39-2					91,487		91,487	12
13	Other (specify): **Speciality Beds**	39-2					92,142		92,142	13
14	TOTAL			\$		\$ 806,043	\$ 418,980		\$ 1,225,023	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

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

0044818

Report Period Beginning: **1-Jan-2009**

Ending:

31-Dec-2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **31-Dec-2009** (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	\$ 350	\$ 5,350	1
2	Cash-Patient Deposits	34,026	34,026	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,905,956	3,905,956	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	39,965	39,965	6
7	Other Prepaid Expenses	12,058	12,058	7
8	Accounts Receivable (owners or related parties)	820	820	8
9	Other(specify): **Refundable deposit**	2,540	2,540	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,995,715	\$ 4,000,715	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		565,000	13
14	Buildings, at Historical Cost		6,815,732	14
15	Leasehold Improvements, at Historical Cost	379,600	934,255	15
16	Equipment, at Historical Cost	591,836	1,239,217	16
17	Accumulated Depreciation (book methods)	(602,224)	(2,331,882)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		21,366	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(21,366)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **Goodwill**)	2,934,268	2,934,268	22
23	Other(specify): **Goodwill Amortization**	(1,092,200)	(1,092,200)	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,211,280	\$ 9,064,390	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,206,995	\$ 13,065,105	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 222,317	\$ 222,317	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,866	33,866	28
29	Short-Term Notes Payable	7,178,575	4,054,777	29
30	Accrued Salaries Payable	534,111	534,111	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,589	20,589	31
32	Accrued Real Estate Taxes(Sch.IX-B)	55,300	55,300	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 8,044,758	\$ 4,920,960	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		8,100,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 8,100,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,044,758	\$ 13,020,960	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,837,763)	\$ 44,145	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,206,995	\$ 13,065,105	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,259,284)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,259,284)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,078,479)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	3,500,000	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 2,421,521	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,837,763)	24 *

* This must agree with page 17, line 47.

XVI. STATEMENT OF CHANGES IN EQUITY

		Total after consolidation	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,367,891)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,367,891)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(587,964)	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)	\$ 4,412,036	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)	\$ 44,145	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Elm Brook Health Care & Rehabilitation Centre # 0044818 Report Period Beginning: 1-Jan-2009Ending: 31-Dec-2009**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	\$ 11,366,021	1
2	Discounts and Allowances for all Levels	(2,359,599)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,006,422	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,758,858	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,758,858	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	223,916	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,619	19
20	Radiology and X-Ray	11,700	20
21	Other Medical Services	38,730	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 294,965	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	63	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 63	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,060,308	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,102,851	31
32	Health Care	4,714,991	32
33	General Administration	2,099,392	33
B. Capital Expense			
34	Ownership	1,897,980	34
C. Ancillary Expense			
35	Special Cost Centers	1,225,023	35
36	Provider Participation Fee	98,550	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,138,787	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,078,479)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,078,479)	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 & 9

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

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

0044818

Report Period Beginning: **1-Jan-2009**

Ending:

31-Dec-2009

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	1,997	2,209	\$ 104,037	\$ 47.10	1
2	Assistant Director of Nursing	2,025	2,205	94,186	42.71	2
3	Registered Nurses	66,640	70,796	1,857,619	26.24	3
4	Licensed Practical Nurses	2,215	2,340	54,216	23.17	4
5	CNAs & Orderlies	143,906	153,170	1,615,679	10.55	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,965	2,054	34,832	16.96	9
10	Activity Assistants	12,023	13,156	336,080	25.55	10
11	Social Service Workers	7,169	7,693	96,506	12.54	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	38,550	41,043	412,249	10.04	15
16	Dishwashers					16
17	Maintenance Workers	5,438	6,053	94,639	15.64	17
18	Housekeepers	38,956	41,708	411,118	9.86	18
19	Laundry	6,163	6,978	67,863	9.73	19
20	Administrator	1,907	2,086	98,569	47.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,484	13,522	191,332	14.15	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	1,768	2,009	31,893	15.88	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	343,206	367,022	\$ 5,500,818 *	\$ 14.99	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	735	\$ 23,399	1-3	35
36	Medical Director	400	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	400	11,975	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	122	3,430	11-3	44
45	Social Service Consultant	171	4,788	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,943	\$ 68,312		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	120	\$ 2,880	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	120	\$ 2,880		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Connie L. Sherman	Administrator	N/A	\$ 98,569	Workers' Compensation Insurance	\$ 76,326	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	31,348	Advertising: Employee Recruitment	1,308	
				FICA Taxes	406,120	Health Care Worker Background Check		
				Employee Health Insurance	177,031	(Indicate # of checks performed <u>182</u>)	2,184	
				Employee Meals	18,737	Patient Background Checks	<u>168</u> 2,016	
				Illinois Municipal Retirement Fund (IMRF)*		***Licenses and Fees***	3,830	
				Retirement Plan Contributions	45,025	***Dues and Subscriptions***	100	
				Misc. Employee Benefits	22,356	***Advertising and Promotions***	13,706	
				Employment Fees		***Lancaster Allocation***	61,101	
				Holiday Expenses	7,718			
				Lancaster Allocation	10,190	Less: Public Relations Expense	(10,004)	
						Non-allowable advertising	(61,101)	
						Yellow page advertising	(3,702)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 98,569	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 794,851		\$ 10,433		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees - Lancaster			\$ 299,040				Out-of-State Travel	\$
							In-State Travel	720
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 299,040				Seminar Expense	5,589
							Lancaster Allocation	1,442
C. Professional Services								
Vendor/Payee	Type		Amount					
Frost Ruttenberg and Rothblatt	Accounting		\$ 1,775				Entertainment Expense	()
Richard Peelo	Accounting		2,250				(agree to Sch. V, line 24, col. 8)	
Personnel Planners	Unemployment Tax Consult.		2,267				TOTAL	\$ 7,751
Health Data Systems, Inc.	Data Processing		7,375					
Accu-med Services, Inc.	Data Processing		4,260					
AT & T	Data Processing		588					
SigmaCare Services	Data Processing		1,800					
LTCAC, Inc.	Data Processing		281					
Stone, Pogrund & Korey	Legal		3,570					
Myers, Miller & Krauskopf	Legal		38,600					
Kenneth A. Henry	Legal		2,596					
Law Office of Carter Korey	Legal		12,465					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 77,827	TOTAL		\$		

* Attach copy of IMRF notifications

**See instructions.

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

1	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							
																	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1	Painting & Decorating	5/2003	\$ 5,700	3	\$ 950	\$	\$	\$	\$	\$	\$	\$	\$											
2	Painting & Decorating	6/2003	2,050	3	342																			
3	Painting & Decorating	2/2004	1,992	3	664	332																		
4	Painting & Decorating	8/2004	1,528	3	509	255																		
5	Painting & Decorating	12/2004	1,968	3	656	328																		
6	Painting & Decorating	3/2005	2,480	3	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	Painting & Decorating	8/2009	525	3				175	175	175														
11																								
12																								
13																								
14																								
15																								
16																								
17																								
18																								
19																								
20	TOTALS		\$ 26,045		\$ 5,022	\$ 4,099	\$ 3,680	\$ 2,369	\$ 1,085	\$ 175	\$	\$	\$											

Facility Name & ID Number Elm Brook Health Care & Rehabilitation Centre# 0044818Report Period Beginning: 1-Jan-2009Ending: 31-Dec-2009**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? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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? N/A
- (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 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 62,988 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. N/A
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 98,550
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. \$ 18,737 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- 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: N/A
- (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.