



Facility Name & ID Number Elmbrook Nursing

# 0051177 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 N/A

	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	176	Skilled (SNF)	176	64,240	1
2		Skilled Pediatric (SNF/PED)			2
3	4	Intermediate (ICF)	4	1,460	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 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	12,513	1,890	11,959	26,362	8
9	SNF/PED					9
10	ICF	26,859	1,493	393	28,745	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,372	3,383	12,352	55,107	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.88%

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 10/01/2010

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 10/01/2010 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 11,020

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/11 Ending: 12/31/11

**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	343,649	37,308	16,073	397,030		397,030		397,030		1
2	Food Purchase		323,540		323,540	(44,413)	279,127	(100)	279,027		2
3	Housekeeping	260,957	23,136	1,048	285,141		285,141	1,043	286,184		3
4	Laundry	69,335	27,991		97,326		97,326		97,326		4
5	Heat and Other Utilities			240,583	240,583		240,583	(4,862)	235,721		5
6	Maintenance	79,973	3,257	164,285	247,515		247,515	(52,843)	194,672		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	753,914	415,232	421,989	1,591,135	(44,413)	1,546,722	(56,762)	1,489,960		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			14,600	14,600		14,600		14,600		9
10	Nursing and Medical Records	3,082,256	256,335	88,010	3,426,601		3,426,601	(47,008)	3,379,593		10
10a	Therapy	145,425	2,733	2,100	150,258		150,258		150,258		10a
11	Activities	193,670	22,063		215,733		215,733		215,733		11
12	Social Services	127,945		905	128,850		128,850		128,850		12
13	CNA Training										13
14	Program Transportation			(1,920)	(1,920)		(1,920)		(1,920)		14
15	Other (specify):*							3,070	3,070		15
16	<b>TOTAL Health Care and Programs</b>	3,549,296	281,131	103,695	3,934,122		3,934,122	(43,938)	3,890,184		16
	<b>C. General Administration</b>										
17	Administrative	354,732		522,987	877,719		877,719	(506,987)	370,732		17
18	Directors Fees										18
19	Professional Services			389,897	389,897		389,897	(299,947)	89,950		19
20	Dues, Fees, Subscriptions & Promotions			205,042	205,042		205,042	(168,525)	36,517		20
21	Clerical & General Office Expenses	101,969	2,617	427,344	531,930		531,930	(218,887)	313,043		21
22	Employee Benefits & Payroll Taxes			684,288	684,288	44,413	728,701		728,701		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,568	1,568		1,568	395	1,963		24
25	Other Admin. Staff Transportation			1,843	1,843		1,843		1,843		25
26	Insurance-Prop.Liab.Malpractice			85,067	85,067		85,067	393	85,460		26
27	Other (specify):*							23,741	23,741		27
28	<b>TOTAL General Administration</b>	456,701	2,617	2,318,036	2,777,354	44,413	2,821,767	(1,169,816)	1,651,951		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,759,911	698,980	2,843,720	8,302,611		8,302,611	(1,270,516)	7,032,095		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number

Elmbrook Nursing

#0051177

Report Period Beginning:

01/01/11

Ending:

12/31/11

## 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			383,703	383,703		383,703	186,051	569,754			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			52,653	52,653		52,653	953,596	1,006,249			32
33	Real Estate Taxes			60,000	60,000		60,000	5,274	65,274			33
34	Rent-Facility & Grounds			1,431,921	1,431,921		1,431,921	(1,431,000)	921			34
35	Rent-Equipment & Vehicles			19,999	19,999		19,999		19,999			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,948,276	1,948,276		1,948,276	(286,080)	1,662,196			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		477,138	1,005,358	1,482,496		1,482,496		1,482,496			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	<b>TOTAL Special Cost Centers</b>		477,138	1,103,908	1,581,046		1,581,046		1,581,046			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,759,911	1,176,118	5,895,904	11,831,933		11,831,933	(1,556,596)	10,275,337			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Elmbrook Nursing**

# **0051177**

Report Period Beginning:

**01/01/11**

Ending:

**12/31/11**

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(7,018)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	181,503	30		9
10	Interest and Other Investment Income	(247)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(199)	02		13
14	Non-Care Related Interest				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	(1,280)	21		18
19	Entertainment				19
20	Contributions	(73,443)	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	(189,895)	21		24
25	Fund Raising, Advertising and Promotional	(91,722)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,478)	20		28
29	Other-Attach Schedule	(298,034)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (483,813)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,072,783)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (1,072,783)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,556,596)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

		1	2	3	4
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
38	Medically Necessary Transport.			\$	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

<b>BHF USE ONLY</b>							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Elmbrook Nursing

ID# 0051177

Report Period Beginning: 01/01/11

Ending: 12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Pharmacy - Veteran	\$ (23,567)	10	1
2	Physical Therapy - Veteran	(1,218)	10	2
3	Occupational Therapy - Veteran	(1,199)	10	3
4	Bank Charges	(6,627)	21	4
5	Building Co. - Accounting Fees	(2,000)	19	5
6	Building Co. - License	(250)	20	6
7	Building Co. - Loan Fees	(56,181)	21	7
8	Building Co. - Professional Fees	(7,500)	19	8
9	Building Co. - State Income Tax	(200)	21	9
10	Capitalized R&M	(83,143)	06	10
11	Additional R&M	9,905	06	11
12	Non-Allowable Legal	(3,047)	19	12
13	Miscellaneous Income	(3,007)	21	13
14	Non-Allowable Fees	(120,000)	21	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>	(298,034)		49

Elmbrook Nursing

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elmbrook Nursing# 0051177

Report Period Beginning:

01/01/11

Ending:

12/31/11

## 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													1
2	Food Purchase	(199)		99									(100)	2
3	Housekeeping			1,043									1,043	3
4	Laundry													4
5	Heat and Other Utilities	(7,018)		2,156									(4,862)	5
6	Maintenance	(73,238)	15,377	5,018									(52,843)	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(80,455)</b>	<b>15,377</b>	<b>8,316</b>									<b>(56,762)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(25,984)				(21,024)							(47,008)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					3,070							3,070	15
16	<b>TOTAL Health Care and Programs</b>	<b>(25,984)</b>				<b>(17,954)</b>							<b>(43,938)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(506,987)									(506,987)	17
18	Directors Fees													18
19	Professional Services	(12,547)	9,500	(297,137)		237							(299,947)	19
20	Fees, Subscriptions & Promotions	(168,893)	250	55	28	35							(168,525)	20
21	Clerical & General Office Expenses	(377,190)	56,881	101,355		67							(218,887)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			395									395	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			393									393	26
27	Other (specify):*			23,741									23,741	27
28	<b>TOTAL General Administration</b>	<b>(558,630)</b>	<b>66,631</b>	<b>(678,184)</b>	<b>28</b>	<b>339</b>							<b>(1,169,816)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(665,069)</b>	<b>82,008</b>	<b>(669,868)</b>	<b>28</b>	<b>(17,615)</b>							<b>(1,270,516)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Elmbrook Nursing# 0051177

Report Period Beginning:

01/01/11

Ending:

12/31/11

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	181,503	(1,921)	643	5,826								186,051	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(247)	948,144	7	5,692								953,596	32
33	Real Estate Taxes				5,274								5,274	33
34	Rent-Facility & Grounds		(1,431,000)	15,345	(15,345)								(1,431,000)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>181,256</b>	<b>(484,777)</b>	<b>15,995</b>	<b>1,446</b>								<b>(286,080)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>													<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(483,813)	(402,769)	(653,873)	1,474	(17,615)							(1,556,596)	45

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6Supp		See Page 6Supp		See Page 6Supp		

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rental Income	\$ 1,431,000	Elmbrook Properties		\$	(1,431,000)	1
2	V	32 Interest	7,777	Elmbrook Properties		955,921	948,144	2
3	V	19 Accounting Fees		Elmbrook Properties		2,000	2,000	3
4	V	30 Depreciation		Elmbrook Properties		(1,921)	(1,921)	4
5	V	06 Grounds Maintenance		Elmbrook Properties		5,357	5,357	5
6	V	20 License		Elmbrook Properties		250	250	6
7	V	21 Loan Fees Expense		Elmbrook Properties		56,181	56,181	7
8	V	19 Professional Fees		Elmbrook Properties		7,500	7,500	8
9	V	06 Repairs & Maintenance		Elmbrook Properties		10,020	10,020	9
10	V	21 State Income Tax		Elmbrook Properties		700	700	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,438,777			\$ 1,036,008	\$ * (402,769)	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	<u>2</u> <u>FOOD</u>	\$	<u>Legacy Healthcare Financial Services</u>	100.00%	\$ 99	\$ 99
16	V	<u>3</u> <u>HOUSEKEEPING</u>		<u>Legacy Healthcare Financial Services</u>	100.00%	1,043	1,043
17	V	<u>5</u> <u>UTILITIES</u>		<u>Legacy Healthcare Financial Services</u>	100.00%	2,156	2,156
18	V	<u>6</u> <u>GROUNDS &amp; MAINTENANCE</u>		<u>Legacy Healthcare Financial Services</u>	100.00%	5,018	5,018
19	V						
20	V	<u>19</u> <u>PROFESSIONAL FEES</u>		<u>Legacy Healthcare Financial Services</u>	100.00%	3,857	3,857
21	V	<u>20</u> <u>FEES, SUBSCRIPTIONS</u>		<u>Legacy Healthcare Financial Services</u>	100.00%	55	55
22	V	<u>21</u> <u>CLERICAL &amp; GENERAL</u>		<u>Legacy Healthcare Financial Services</u>	100.00%	101,355	101,355
23	V	<u>24</u> <u>SEMINARS</u>		<u>Legacy Healthcare Financial Services</u>	100.00%	395	395
24	V	<u>26</u> <u>INSURANCE</u>		<u>Legacy Healthcare Financial Services</u>	100.00%	393	393
25	V	<u>27</u> <u>EMP. BEN.-GEN. ADMIN.</u>		<u>Legacy Healthcare Financial Services</u>	100.00%	23,741	23,741
26	V	<u>30</u> <u>DEPRECIATION</u>		<u>Legacy Healthcare Financial Services</u>	100.00%	643	643
27	V	<u>32</u> <u>INTEREST</u>		<u>Legacy Healthcare Financial Services</u>	100.00%	7	7
28	V	<u>34</u> <u>RENT</u>		<u>Legacy Healthcare Financial Services</u>	100.00%	15,345	15,345
29	V						
30	V						
31	V	<u>17</u> <u>MANAGEMENT FEES</u>	522,987	<u>Legacy Healthcare Financial Services</u>	100.00%		(522,987)
32	V	<u>19</u> <u>BOOKKEEPING FEES</u>	300,994	<u>Legacy Healthcare Financial Services</u>	100.00%		(300,994)
33	V						
34	V	<u>17</u> <u>MANAGEMENT FEES- C. RAJCHENBACH</u>		<u>Legacy Healthcare Financial Services</u>	100.00%	8,000	8,000
35	V	<u>17</u> <u>MANAGEMENT FEES- M. SHABAT</u>		<u>Legacy Healthcare Financial Services</u>	100.00%	8,000	8,000
36	V						
37	V						
38	V						
39	Total		\$ 823,981			\$ 170,107	\$ * (653,873)

\* 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	20 DUES & SUBSCRIPTIONS		Legacy Real Properties	100.00%	28	\$	28	15
16	V	30 DEPRECIATION		Legacy Real Properties	100.00%	5,826		5,826	16
17	V	32 INTEREST EXPENSE		Legacy Real Properties	100.00%	5,692		5,692	17
18	V	33 REAL ESTATE TAXES		Legacy Real Properties	100.00%	5,274		5,274	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V	34 RENT	15,345	Legacy Real Properties	100.00%			(15,345)	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		\$ 15,345			\$ 16,819	\$ *	1,474	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10 RN SALARY		Progressive Healthcare Consulting	100.00%	37,476	\$ 37,476
16	V	15 EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	3,070	3,070
17	V	19 PROFESSIONAL FEES		Progressive Healthcare Consulting	100.00%	237	237
18	V	20 FEES, SUBSCRIPTIONS		Progressive Healthcare Consulting	100.00%	35	35
19	V	21 CLERICAL & GENERAL		Progressive Healthcare Consulting	100.00%	67	67
20	V						
21	V						
22	V	10 NURSING	58,500	Progressive Healthcare Consulting	100.00%		(58,500)
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		\$ 58,500			\$ 40,885	\$ * (17,615)

\* 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		\$			\$	\$	15
16	V							16
17	V							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	<b>Total</b>		\$			\$	\$ *	39

\* 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							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	<b>Total</b>		\$			\$	\$ *	39

\* 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							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	<b>Total</b>		\$			\$	\$ *	39

\* 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		\$			\$	\$	15
16	V							16
17	V							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	<b>Total</b>		\$			\$	\$ *	39

\* 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		\$			\$	\$	15
16	V							16
17	V							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	<b>Total</b>		\$			\$	\$ *	39

\* 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		\$			\$	\$	15
16	V							16
17	V							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	<b>Total</b>		\$			\$	\$ *	39

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ADINA FEINER	4.000%	ASTORIA PLACE LIVING AND REHABILITATION CENTER,LLC	CHICAGO	PROGRESSIVE HEALTHCARE	LINCOLNWOOD	CONSULTING	1
2	AVROHOM RAJCHENBACH/CHANA RAJCHENBACH	2.500%	THE GROVE NORTH LIVING AND REHAB CENTER,LLC	SKOKIE	LEGACY REAL PROPERTIES , I	LINCOLNWOOD	BUILDING CO	2
3	CHAIM RAJCHENBACH	25.000%	THE GROVE OF EVANSTON,LLC	EVANSTON	LEGACY HEALTHCARE & FINA	LINCOLNWOOD	HOME OFFICE / BOOKK	3
4	CHAVIVA FEINER	4.000%	THE GROVE OF LAGRANGE PARK,LLC	LAGRANGE PARK				4
5	DEMETRIOS KOUZIOS	5.000%	THE GROVE AT LINCOLN PARK LIVING AND REHAB CENTER,LLC	CHICAGO				5
6	ISAAC WEISS	10.000%	THE GROVE AT THE LAKE LIVING AND REHABILITATION, LLC	ZION				6
7	JACK RAJCHENBACH FAMILY TRUST	2.500%	LAKEFRONT NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO				7
8	MENACHEM SHABAT	25.000%	PARK VILLA NURSING AND REHABILITATION CENTER,LLC	MELROSE PARK				8
9	PINCHAS SCHWARTZ/NAHAM SCHWARTZ	2.500%	PETERSON PARK ASSOCIATES LIMITED PARTNERSHIP	CHICAGO				9
10	RONALD SHABAT	12.500%	WINDSOR PARK	CHICAGO				10
11	SHLOMO ZALMAN BUSEL/CHAVA BUSEL	2.500%						11
12	YOSEPH RAJCHENBACH/NAOMI ZISEL RAJCHENBACH	2.500%						12
13	ZVI FEINER	2.000%						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

**VII. RELATED PARTIES**

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Elmbrook Nursing

# 0051177

Report Period Beginning:

01/01/11

Ending:

12/31/11

## 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	Demetrios Kouzious	Administrator	Administrative	5.00%	None	40	100.00%	Salary	\$ 193,985	17-01	1
2	Chaim Rajchenbach	Owner	Administrative	25.00%	See Attached	2	4.00%	Mgmt. Fees	8,000	17-07	2
3	Menachem Shabat	Owner	Administrative	25.00%	See Attached	2	4.00%	Mgmt. Fees	8,000	17-07	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 209,985		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	1
2									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	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmbrook Nursing

# 0051177

Report Period Beginning:

01/01/11

Ending: 12/31/11

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 Legacy Healthcare Financial Services  
 Street Address 7040 N. Ridgeway  
 City / State / Zip Code Lincolnwood, IL 60712  
 Phone Number ( 847) 679-9797  
 Fax Number ( 847) 679-1126

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	2	FOOD	AVAIL. BED DAYS	590,233	12	\$ 890	\$ 65,700	\$ 99	1	
2	3	HOUSEKEEPING	AVAIL. BED DAYS	590,233	12	9,370	9,260	65,700	1,043	2
3	5	UTILITIES	AVAIL. BED DAYS	590,233	12	19,367		65,700	2,156	3
4	6	GROUNDS & MAINTENANCE	AVAIL. BED DAYS	590,233	12	45,083	9,228	65,700	5,018	4
5										5
6	19	PROFESSIONAL FEES	AVAIL. BED DAYS	590,233	12	34,648		65,700	3,857	6
7	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	590,233	12	493		65,700	55	7
8	21	CLERICAL & GENERAL	AVAIL. BED DAYS	590,233	12	910,553	832,276	65,700	101,355	8
9	24	SEMINARS	AVAIL. BED DAYS	590,233	12	3,552		65,700	395	9
10	26	INSURANCE	AVAIL. BED DAYS	590,233	12	3,535		65,700	393	10
11	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	590,233	12	213,280		65,700	23,741	11
12	30	DEPRECIATION	AVAIL. BED DAYS	590,233	12	5,774		65,700	643	12
13	32	INTEREST	AVAIL. BED DAYS	590,233	12	62		65,700	7	13
14	34	RENT	AVAIL. BED DAYS	590,233	12	137,855		65,700	15,345	14
15										15
16	17	MANAGEMENT FEES- C. RAJ	AVG HOURS WKD	50	11	200,000		2	8,000	16
17	17	MANAGEMENT FEES- M. SHA	AVG HOURS WKD	50	11	200,000		2	8,000	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,784,461	\$ 850,764	\$ 170,107		25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmbrook Nursing

# 0051177

Report Period Beginning:

01/01/11

Ending: 12/31/11

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 Legacy Real Properties  
 Street Address 7040 N. Ridgeway  
 City / State / Zip Code Lincolnwood, IL 60712  
 Phone Number ( 847) 679-9797  
 Fax Number ( 847) 679-1126

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	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	590,233	12	250	65,700	28	1
2	30	DEPRECIATION	AVAIL. BED DAYS	590,233	12	52,340	65,700	5,826	2
3	32	INTEREST EXPENSE	AVAIL. BED DAYS	590,233	12	51,132	65,700	5,692	3
4	33	REAL ESTATE TAXES	AVAIL. BED DAYS	590,233	12	47,377	65,700	5,274	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	TOTALS					\$ 151,099	\$	\$ 16,819	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmbrook Nursing

# 0051177

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization Progressive Healthcare Consulting  
 Street Address 7040 N. Ridgeway  
 City / State / Zip Code Lincolnwood, IL 60712  
 Phone Number ( 847) 679-9797  
 Fax Number ( 847) 679-1126

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.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	10	RN SALARY	AVAIL. BED DAYS	465,768	10	265,681	265,681	65,700	37,476	1
2	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	465,768	10	21,767		65,700	3,070	2
3	19	PROFESSIONAL FEES	AVAIL. BED DAYS	465,768	10	1,681		65,700	237	3
4	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	465,768	10	250		65,700	35	4
5	21	CLERICAL & GENERAL	AVAIL. BED DAYS	465,768	10	472		65,700	67	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	TOTALS					\$ 289,851	\$ 265,681		\$ 40,885	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/11 Ending: 12/31/11

**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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	1
2									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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmbrook Nursing

# 0051177

Report Period Beginning:

01/01/11

Ending: 12/31/11

**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 \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	1
2									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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmbrook Nursing

# 0051177

Report Period Beginning:

01/01/11

Ending: 12/31/11

**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 \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	1
2									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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmbrook Nursing

# 0051177

Report Period Beginning:

01/01/11

Ending: 12/31/11

**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 \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	1
2									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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmbrook Nursing

# 0051177 Report Period Beginning: 01/01/11 Ending: 12/31/11

**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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	1
2									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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	1
2									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	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Elmbrook Nursing

# 0051177

Report Period Beginning:

01/01/11

Ending:

12/31/11

## 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	Reporting Period Interest Expense										
												Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)
													YES	NO				Original	Balance		
	<b>A. Directly Facility Related</b>																				
	<b>Long-Term</b>																				
1	Private Bank		X	Mortgage Note			\$	\$ 9,525,000			\$ 661,723	1									
2	Seller Note		X					3,870,000			241,954	2									
3												3									
4												4									
5	See Supplemental Schedule											5									
	<b>Working Capital</b>																				
6	Private Bank		X	Line of Credit		10/19/11		2,500,000	2,260,000	10/19/12		50,824	6								
7	Liab Insurance		X	Working Capital/liab. Insurance								1,154	7								
8	See Supplemental Schedule								1,000,000			58,618	8								
9	TOTAL Facility Related						\$ 2,500,000	\$ 16,655,000			\$ 1,014,273	9									
	<b>B. Non-Facility Related*</b>																				
10	Interest Income		X									(247)	10								
11	Bldg. Co. - Interest Income		X									(7,777)	11								
12													12								
13	See Supplemental Schedule												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (8,024)	14									
15	TOTALS (line 9+line14)						\$ 2,500,000	\$ 16,655,000			\$ 1,006,249	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ None                      Line # N/A

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name &amp; ID Number

Elmbrook Nursing

# 0051177

Report Period Beginning:

01/01/11

Ending:

12/31/11

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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								
6												6								
7	<b>TOTAL Long-Term</b>																			
	<b>Working Capital</b>																			
8	Liab Insurance		X			7/1/11	\$	\$	6/30/12		\$ 675	8								
9	Capex Line of Credit - # 12382		X	Line of Credit				1,000,000			41,354	9								
10											10,890	10								
11	Alloc. From Legacy Real Prop.										5,692	11								
12	Alloc. From Legacy Healthcare										7	12								
13												13								
14	<b>TOTAL Working Capital</b>																			
	<b>B. Non-Facility Related*</b>																			
15							\$	\$			\$	15								
16												16								
17												17								
18												18								
19												19								
20	<b>TOTAL Non-Facility Related</b>																			

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* 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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2010 report.		\$	<b>59,649</b>		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>62,956</b>		2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>3,307</b>		3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>61,967</b>		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>65,274</b>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2006	_____			8
	2007	_____			9
	2008	_____			10
	2009	_____			11
	2010	<b>57,682</b>			12
<b>2011 Accrual = \$57,682 x 1.07 = \$61,967</b>					
<b>Allocated from Legacy Real Properties = \$5,274</b>					
<b>FOR BHF USE ONLY</b>					
	13	FROM R. E. TAX STATEMENT FOR 2010	\$		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.**

**SEE ACCOUNTANTS' COMPILATION REPORT**



# 2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Elmbrook Nursing COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0051177

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 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 2000.

	(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.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
<b>TOTALS</b>			\$ _____	\$ _____

**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        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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Elmbrook Nursing

# 0051177

Report Period Beginning:

01/01/11

Ending:

12/31/11

**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: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>67,000</u>	<u>2010</u>	<u>\$ 1,309,500</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>67,000</b>		<b>\$ 1,309,500</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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		2010	1977	\$ 6,704,615	\$	39	\$ 171,913	\$ 171,913	\$ 214,892
5										
6										
7										
8										
	<b>Improvement Type**</b>									
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
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

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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		39,985			1,999	1,999	3,999	67
68		140,125	3,899		5,709	1,810	10,316	68
69			381,782			(381,782)		69
70		\$ 6,884,725	\$ 385,681		\$ 179,621	\$ (206,060)	\$ 229,206	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Elmbrook Nursing

# 0051177

Report Period Beginning:

01/01/11

Ending:

12/31/11

## XI. OWNERSHIP COSTS (continued)

## B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 6,884,725	\$ 385,681		\$ 179,621	\$ (206,060)	\$ 229,206	1
2	Sprinklers - Systems Piping #2354	2011	6,826		20	171	171	171	2
3	Remodeling- Demolish Walls, New Walls, Paint	2011	4,650		20	116	116	116	3
4	3Rd Floor Bathrooms - Plumbing, Paint, Tile	2011	7,680		20				4
5	Replace Compressor On Air Conditioning Unit	2011	20,565		20				5
6	Replace Lining For Cooling Tower	2011	3,960		20				6
7	New Phone System	2011	40,465		20				7
8	Resident Rooms - Built In Furniture/Drywall/Wallpaper/Paint/Bas	2011	106,719		20				8
9	Sliding Door/Entrance	2011	5,123		20				9
10	Interior Signage	2011	9,825		20				10
11	Exterior Signage	2011	13,270		20				11
12	Electrical - Phone Jack Intallation/Low Voltage/Duplex Outlets	2011	68,690		20				12
13	Land Improvements - Paint Fence, Paving	2011	54,784		20				13
14	Project A - Lobby - Tiling/Crown Molding/Window/Wall Covering	2011	31,193		20				14
15	Project B - 1St Floor Cooridor - Handrails/Flooring/Tiling/Wallpa	2011	111,212		20				15
16	Project C - 1St Floor Resident Rooms - New Fixtures/Built In Hea	2011	68,523		20				16
17	Project D - 2Nd Floor Resident Rooms - Light Fixtures/Headboard	2011	74,380		20				17
18	Project E - 2Nd Floor Therapy Rooms - Dividing Wall/Wallpaper/	2011	40,936		20				18
19	Project F - 2Nd Floor Therapy Bathrooms - Flooring/Fixtures	2011	5,709		20				19
20	Project G - 3Rd Floor Resident Rooms - Light Fixtures/Paint/Win	2011	25,239		20				20
21	Project H - Front Offices - Flooring/Paint/Window	2011	17,943		20				21
22	Project I - Elevator - Cab Systems	2011	15,108		20				22
23	Project J - 1St Floor Nurses Station - Charting Unit/Railing/Tiling	2011	13,307		20				23
24	Project K - Resident Bathrooms - Flooring/Painting	2011	8,315		20				24
25	Project L - 2Nd Floor Nurses Station - Nurses Station/Charting Ur	2011	11,652		20				25
26	Project M - 2Nd Floor Dining Room - Flooring/Wallcovering/Win	2011	24,849		20				26
27	Project N - 3Rd Floor Nurses Station - Nurses Station/Charting Ur	2011	11,652		20				27
28	Project O - 3Rd Floor Corridor - Flooring/Cove Base	2011	33,005		20				28
29	Project P - 3Rd Floor Dining Room - Flooring/Molding/Wallpaper/	2011	36,984		20				29
30	Project Q - 2Nd Floor Corridor - Tiling/Flooring/Crown Molding/	2011	65,334		20				30
31	Wallpaper, Drywall, Paint	2011	2,800		20				31
32	Air Conditioning Unit	2011	4,250		20				32
33	Corner Guards, Lighting, Signage, Wallpaper	2011	4,176		20				33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,833,849	\$ 385,681		\$ 179,908	\$ (205,773)	\$ 229,493	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 7,833,849	\$ 385,681		\$ 179,908	\$ (205,773)	\$ 229,493	1
2	Custom Signage	2011	8,723		20				2
3	Wallpaper, Paint, Locks, Power Outlets	2011	5,325		20				3
4	Wallpaper, Paint, Baseboards	2011	5,100		20				4
5	Exterior Caulking	2011	5,500		20				5
6	Front Entrance - Fix Damaged Floor, Paint	2011	2,950		20				6
7	Air Handler Repair	2011	2,609		20				7
8	Chiller Repair	2011	6,194		20				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	TOTAL (lines 1 thru 33)		\$ 7,870,250	\$ 385,681		\$ 179,908	\$ (205,773)	\$ 229,493	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 7,870,250	\$ 385,681		\$ 179,908	\$ (205,773)	\$ 229,493	1
2								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	TOTAL (lines 1 thru 33)	\$ 7,870,250	\$ 385,681		\$ 179,908	\$ (205,773)	\$ 229,493	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 7,870,250	\$ 385,681		\$ 179,908	\$ (205,773)	\$ 229,493	1
2								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	TOTAL (lines 1 thru 33)	\$ 7,870,250	\$ 385,681		\$ 179,908	\$ (205,773)	\$ 229,493	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Building Company Information</b>								1
2	<b>Buildings:</b>								2
3									3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	Plumbing	2010	2,450		20	123	123	245	9
10	Painting	2010	16,235		20	812	812	1,624	10
11	Security System	2010	14,800		20	740	740	1,480	11
12	Plumbing	2010	6,500		20	325	325	650	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$	\$		\$	\$	\$	1
2								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	<b>TOTAL (12F &amp; 12G lines 1 thru 33)</b>	\$	\$		\$	\$	\$	34
			39,985		1,999	1,999	3,999	

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Related Party Information</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3	Allocated from Legacy Real Properties	2009	70,556	2,306	35	2,352	46	5,880	3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	Allocated from Legacy Real Properties	2009	40,068	924	20	2,003	1,079	2,838	9
10	Allocated from Legacy Real Properties	2010	12,184	287	20	488	201	732	10
11	Allocated from Legacy Real Properties	2011	17,317	382	20	866	484	866	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1								1	
2								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	TOTAL (12H & 12I lines 1 thru 33)		\$ 140,125	\$ 3,899		\$ 5,709	\$ 1,810	\$ 10,316	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Elmbrook Nursing

# 0051177

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 1,904,788	\$ 2,570	\$ 379,010	\$ 376,440	10	\$ 474,711	71
72	Current Year Purchases	278,336		10,836	10,836	10	10,836	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,183,124	\$ 2,570	\$ 389,846	\$ 387,276		\$ 485,547	75

D. Vehicle Costs. (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)	\$ 11,362,873	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 388,251	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 569,754	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 181,503	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 715,040	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.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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	Portable Storage				921			6
7	TOTAL				\$ 921			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: \$ 19,999 Description: See Attached Schedule

(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. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2013 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2014 \$ \_\_\_\_\_

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs				\$ 444,724				\$ 444,724	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				89,175				89,175	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				402,697				402,697	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescrpts					425,584			425,584	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): <u>See Supplemental</u>						68,762	51,554			120,316	13
14	TOTAL				\$		\$ 1,005,358	\$ 477,138			\$ 1,482,496	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Elmbrook Nursing**

# **0051177**

Report Period Beginning: **01/01/11**

Ending:

**12/31/11**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/11**

(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	\$ 14,884	\$ 1,706,147	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	4,458,064	4,458,064	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	25,620	25,620	6
7	Other Prepaid Expenses		25,000	7
8	Accounts Receivable (owners or related parties)	354,862	354,862	8
9	Other(specify): <u>See Attached Schedule</u>	68,383	181,383	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 4,921,813</b>	<b>\$ 6,751,076</b>	<b>10</b>
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,309,500	13
14	Buildings, at Historical Cost		5,225,183	14
15	Leasehold Improvements, at Historical Cost	10,453	1,307,131	15
16	Equipment, at Historical Cost	1,954,388	2,029,853	16
17	Accumulated Depreciation (book methods)	(411,395)	(447,444)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	3,690,000	3,821,475	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 5,243,446</b>	<b>\$ 13,245,698</b>	<b>24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 10,165,259</b>	<b>\$ 19,996,774</b>	<b>25</b>

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 522,033	\$ 522,033	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	474,898	474,898	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,224	17,224	31
32	Accrued Real Estate Taxes(Sch.IX-B)	61,967	61,967	32
33	Accrued Interest Payable	9,501	90,840	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>	329,350	503,887	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	<b>\$ 1,414,973</b>	<b>\$ 1,670,849</b>	<b>38</b>
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	2,260,000	7,130,000	39
40	Mortgage Payable		9,525,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	<b>\$ 2,260,000</b>	<b>\$ 16,655,000</b>	<b>45</b>
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	<b>\$ 3,674,973</b>	<b>\$ 18,325,849</b>	<b>46</b>
47	<b>TOTAL EQUITY(page 18, line 24)</b>	<b>\$ 6,490,286</b>	<b>\$ 1,670,925</b>	<b>47</b>
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	<b>\$ 10,165,259</b>	<b>\$ 19,996,774</b>	<b>48</b>

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>5,361,099</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>5,361,099</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>1,129,187</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>1,129,187</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>6,490,286</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$ 9,930,416	1
2	Discounts and Allowances for all Levels	894,018	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 10,824,434</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,740,014	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,740,014</b>	<b>8</b>
<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	351,932	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	41,486	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 393,418</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	247	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 247</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	3,007	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 3,007</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 12,961,120</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,591,135	31
32	Health Care	3,934,122	32
33	General Administration	2,777,354	33
<b>B. Capital Expense</b>			
34	Ownership	1,948,276	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,482,496	35
36	Provider Participation Fee	98,550	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 11,831,933</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>1,129,187</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 1,129,187</b>	<b>43</b>

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Elmbrook Nursing**

# **0051177**

Report Period Beginning:

**01/01/11**

Ending:

**12/31/11**

**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	1,462	1,511	\$ 66,258	\$ 43.85	1
2	Assistant Director of Nursing	1,629	1,654	57,948	35.04	2
3	Registered Nurses	47,937	53,356	1,385,033	25.96	3
4	Licensed Practical Nurses	12,487	13,022	309,390	23.76	4
5	CNAs & Orderlies	93,239	101,288	1,232,437	12.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,870	7,798	145,425	18.65	8
9	Activity Director	1,974	2,160	38,230	17.70	9
10	Activity Assistants	8,556	9,833	155,440	15.81	10
11	Social Service Workers	7,533	7,897	127,945	16.20	11
12	Dietician					12
13	Food Service Supervisor	1,933	2,142	48,973	22.86	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,726	28,488	294,676	10.34	15
16	Dishwashers					16
17	Maintenance Workers	3,780	4,241	79,973	18.86	17
18	Housekeepers	19,709	22,268	260,957	11.72	18
19	Laundry	5,170	6,325	69,335	10.96	19
20	Administrator	4,601	4,728	327,788	69.33	20
21	Assistant Administrator	1,072	1,120	26,944	24.06	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,443	8,090	101,969	12.60	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	90	90	3,417	37.97	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,908	2,118	27,773	13.11	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	253,119	278,129	\$ 4,759,911 *	\$ 17.11	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	339	\$ 16,073	01-03	35
36	Medical Director	Monthly	14,600	09-03	36
37	Medical Records Consultant	8	376	10-03	37
38	Nurse Consultant	Monthly	75,000	10-03	38
39	Pharmacist Consultant	Monthly	12,634	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	2,100	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	9	805	12-03	45
46	Other(specify)				46
47	Clergy	Per Visit	100	12-03	47
48					48
49	TOTAL (lines 35 - 48)	356	\$ 121,688		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT



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								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmbrook Nursing# 0051177Report Period Beginning: 01/01/11Ending: 12/31/11**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. ICLTC: \$17,982
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? 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. \$ 60,967 Line Line 10
- (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. None
- (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. \$ 44,413 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? 100% ln 14  
d. Have vehicle usage logs been maintained? No  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: 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.

**SEE ACCOUNTANTS' COMPILATION REPORT**