



Facility Name & ID Number Elmbrook Nursing

# 0051177 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	13,197	2,810	11,307	27,314	8
9	SNF/PED					9
10	ICF	28,301	2,218	758	31,277	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,498	5,028	12,065	58,591	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.18%

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 176 and days of care provided 10,556

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: 12/31/2013 Fiscal Year: 12/31/2013

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Elmbrook Nursing

# 0051177

Report Period Beginning:

01/01/13

Ending:

12/31/13

**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	359,082	42,613	17,821	419,516		419,516	419,516			1
2	Food Purchase		350,777		350,777	(45,727)	305,050	(7,763)	297,287		2
3	Housekeeping	246,454	26,570	225	273,249		273,249	1,160	274,409		3
4	Laundry	88,054	18,377		106,431		106,431		106,431		4
5	Heat and Other Utilities			246,705	246,705		246,705	(3,978)	242,727		5
6	Maintenance	128,994	1,234	154,510	284,738		284,738	12,146	296,884		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	822,584	439,571	419,261	1,681,416	(45,727)	1,635,689	1,565	1,637,254		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			36,100	36,100		36,100		36,100		9
10	Nursing and Medical Records	3,274,540	256,972	142,164	3,673,676		3,673,676	(61,012)	3,612,664		10
10a	Therapy	218,620	5,568	1,830	226,018		226,018		226,018		10a
11	Activities	184,881	15,165		200,046		200,046		200,046		11
12	Social Services	94,591		5,336	99,927		99,927	6,011	105,938		12
13	CNA Training										13
14	Program Transportation			337	337		337		337		14
15	Other (specify):*							295	295		15
16	<b>TOTAL Health Care and Programs</b>	3,772,632	277,705	185,767	4,236,104		4,236,104	(54,706)	4,181,398		16
	<b>C. General Administration</b>										
17	Administrative	160,840		32,454	193,294		193,294	15,758	209,052		17
18	Directors Fees										18
19	Professional Services			391,699	391,699		391,699	(263,307)	128,392		19
20	Dues, Fees, Subscriptions & Promotions			204,607	204,607		204,607	(168,520)	36,087		20
21	Clerical & General Office Expenses	304,359	6,824	437,967	749,150		749,150	(196,125)	553,025		21
22	Employee Benefits & Payroll Taxes			831,967	831,967	45,727	877,694		877,694		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,133	5,133		5,133	1,173	6,306		24
25	Other Admin. Staff Transportation			11,005	11,005		11,005		11,005		25
26	Insurance-Prop.Liab.Malpractice			159,920	159,920		159,920	5,597	165,517		26
27	Other (specify):*							35,003	35,003		27
28	<b>TOTAL General Administration</b>	465,199	6,824	2,074,752	2,546,775	45,727	2,592,502	(570,421)	2,022,081		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,060,415	724,100	2,679,780	8,464,295		8,464,295	(623,562)	7,840,733		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.

## 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			461,121	461,121		461,121	277,054	738,175			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,424	5,424		5,424	353,350	358,774			32
33	Real Estate Taxes			63,436	63,436		63,436	3,590	67,026			33
34	Rent-Facility & Grounds			937,787	937,787		937,787	(937,787)	(0)			34
35	Rent-Equipment & Vehicles			7,171	7,171		7,171		7,171			35
36	Other (specify):*							119,906	119,906			36
37	<b>TOTAL Ownership</b>			1,474,939	1,474,939		1,474,939	(183,887)	1,291,052			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		296,657	1,168,364	1,465,021		1,465,021		1,465,021			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			376,301	376,301		376,301		376,301			42
43	Other (specify):*	49,964		783,765	833,729		833,729	(833,729)	0			43
44	<b>TOTAL Special Cost Centers</b>	49,964	296,657	2,328,430	2,675,051		2,675,051	(833,729)	1,841,322			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,110,379	1,020,757	6,483,149	12,614,285		12,614,285	(1,641,178)	10,973,107			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: 01/01/13

Ending: 12/31/13

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(5,319)	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	79,197	30		9
10	Interest and Other Investment Income	(7,020)	32		10
11	Discounts, Allowances, Rebates & Refunds	(7,484)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(301)	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	(19,848)	21		18
19	Entertainment				19
20	Contributions	(91,250)	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	(241,577)	21		24
25	Fund Raising, Advertising and Promotional	(71,403)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(8,075)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(947,857)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (1,320,937)</b>		<b>\$</b>	<b>30</b>

BHF USE ONLY					
48		49	50	51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(320,241)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (320,241)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ (1,641,178)</b>		<b>37</b>

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

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

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>	<b>47</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Elmbrook NursingID# 0051177Report Period Beginning: 01/01/13Ending: 12/31/13

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Additional R&M	\$ 8,468	06	1
2	Annual Report	(250)	20	2
3	Veterans Expense	(17,282)	10	3
4	Sequestration	(70,294)	21	4
5	Miscellaneous Income	(20)	21	5
6	Patient Personal Items	(884)	10	6
7	Meals	(549)	21	7
8	Bank Charges	(7,462)	21	8
9	Non-Allowable Legal	(9,011)	19	9
10	Non-Allowable Seminars	(326)	24	10
11	Building Co - Accounting Fees	(2,000)	19	11
12	Building Co - Closing Costs	(661)	21	12
13	Building Co - Legal	(1,469)	19	13
14	Building Co - License	(250)	20	14
15	Building Co - Loan Fee	(3,044)	21	15
16	Building Co - Penalties	(104)	21	16
17	Building Co - Professional Fees	(118)	19	17
18	Building Co - State Income Tax	(2,583)	21	18
19	Marketing Salary	(49,964)	43	19
20	Non-Allowable Expense	(783,765)	43	20
21	COPE Dues	(6,290)	20	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>	(947,857)	49

Elmbrook Nursing

ID# 0051177

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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	<b>Total</b>		0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elmbrook Nursing# 0051177

Report Period Beginning:

01/01/13

Ending:

12/31/13

## 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	(7,785)		22									(7,763)	2
3	Housekeeping			1,160									1,160	3
4	Laundry													4
5	Heat and Other Utilities	(5,319)		1,341									(3,978)	5
6	Maintenance	8,468		3,678									12,146	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(4,636)</b>		<b>6,201</b>									<b>1,565</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(18,166)				(42,846)							(61,012)	10
10a	Therapy													10a
11	Activities													11
12	Social Services					6,011							6,011	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					295							295	15
16	<b>TOTAL Health Care and Programs</b>	<b>(18,166)</b>				<b>(36,540)</b>							<b>(54,706)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(1)		15,758							15,758	17
18	Directors Fees													18
19	Professional Services	(12,598)	3,587	(254,655)		359							(263,307)	19
20	Fees, Subscriptions & Promotions	(169,443)	250	614	30	30							(168,520)	20
21	Clerical & General Office Expenses	(354,217)	6,392	149,751		1,948							(196,125)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(326)		1,432		67							1,173	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice		4,366	1,231									5,597	26
27	Other (specify):*			34,249		754							35,003	27
28	<b>TOTAL General Administration</b>	<b>(536,584)</b>	<b>14,595</b>	<b>(67,379)</b>	<b>30</b>	<b>18,917</b>							<b>(570,421)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(559,386)</b>	<b>14,595</b>	<b>(61,178)</b>	<b>30</b>	<b>(17,623)</b>							<b>(623,562)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Elmbrook Nursing# 0051177

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	79,197	190,941	2,843	4,073								277,054	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(7,020)	356,946	20	3,404								353,350	32
33	Real Estate Taxes				3,590								3,590	33
34	Rent-Facility & Grounds		(937,787)	10,748	(10,748)								(937,787)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*		119,906										119,906	36
37	<b>TOTAL Ownership</b>	<b>72,177</b>	<b>(269,994)</b>	<b>13,611</b>	<b>319</b>								<b>(183,887)</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):*	(833,729)											(833,729)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(833,729)</b>											<b>(833,729)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(1,320,937)	(255,399)	(47,568)	348	(17,623)							(1,641,178)	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 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent Income	\$ 937,787	Elmbrook Properties	100.00%	\$	\$ (937,787)	1
2	V	19 Accounting Fees		Elmbrook Properties	100.00%	2,000	2,000	2
3	V	21 Closing Costs		Elmbrook Properties	100.00%	661	661	3
4	V	30 Depreciation		Elmbrook Properties	100.00%	190,941	190,941	4
5	V	26 Insurance		Elmbrook Properties	100.00%	4,366	4,366	5
6	V	32 Interest	157	Elmbrook Properties	100.00%	357,103	356,946	6
7	V	19 Legal		Elmbrook Properties	100.00%	1,469	1,469	7
8	V	20 License		Elmbrook Properties	100.00%	250	250	8
9	V	21 Loan Fee		Elmbrook Properties	100.00%	3,044	3,044	9
10	V	36 Mortgage Insurance		Elmbrook Properties	100.00%	119,906	119,906	10
11	V	21 Penalties		Elmbrook Properties	100.00%	104	104	11
12	V	19 Professional Fees		Elmbrook Properties	100.00%	118	118	12
13	V	21 State Income Tax		Elmbrook Properties	100.00%	2,583	2,583	13
14	Total		\$ 937,944			\$ 682,545	\$ * (255,399)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	2	FOOD	Legacy Healthcare Financial Services	100.00%	\$ 22	\$	22	15
16	V	3	HOUSEKEEPING WAGES	Legacy Healthcare Financial Services	100.00%	1,034		1,034	16
17	V	3	HOUSEKEEPING SUPPLIES	Legacy Healthcare Financial Services	100.00%	125		125	17
18	V	5	UTILITIES	Legacy Healthcare Financial Services	100.00%	1,341		1,341	18
19	V	6	GROUNDS & MAINTENANCE	Legacy Healthcare Financial Services	100.00%	3,678		3,678	19
20	V	17	MANAGEMENT FEES	Legacy Healthcare Financial Services	100.00%				20
21	V	19	PROFESSIONAL FEES	Legacy Healthcare Financial Services	100.00%	9,345		9,345	21
22	V	20	FEES, SUBSCRIPTIONS	Legacy Healthcare Financial Services	100.00%	614		614	22
23	V	21	CLERICAL & GENERAL WAGES	Legacy Healthcare Financial Services	100.00%	137,993		137,993	23
24	V	21	CLERICAL & GENERAL OTHER COSTS	Legacy Healthcare Financial Services	100.00%	11,759		11,759	24
25	V	24	SEMINARS	Legacy Healthcare Financial Services	100.00%	1,432		1,432	25
26	V	26	INSURANCE	Legacy Healthcare Financial Services	100.00%	1,231		1,231	26
27	V	27	EMP. BEN.-GEN. ADMIN.	Legacy Healthcare Financial Services	100.00%	23,458		23,458	27
28	V	27	EMP BEN- OWNERS	Legacy Healthcare Financial Services	100.00%				28
29	V	30	DEPRECIATION	Legacy Healthcare Financial Services	100.00%	2,843		2,843	29
30	V	32	INTEREST	Legacy Healthcare Financial Services	100.00%	20		20	30
31	V	34	RENT	Legacy Healthcare Financial Services	100.00%	10,748		10,748	31
32	V								32
33	V	17	MANAGEMENT FEES	Legacy Healthcare Financial Services	100.00%			(32,454)	33
34	V	19	BOOKKEEPING FEES	Legacy Healthcare Financial Services	100.00%			(264,000)	34
35	V	17	MANAGEMENT FEES- C. RAJCHENBACH	Legacy Healthcare Financial Services	100.00%	16,227		16,227	35
36	V	17	MANAGEMENT FEES- M. SHABAT	Legacy Healthcare Financial Services	100.00%	16,227		16,227	36
37	V	27	HEALTH INSURANCE/BENEFITS- C. RAJCHENBACH	Legacy Healthcare Financial Services	100.00%	5,396		5,396	37
38	V	27	HEALTH INSURANCE/BENEFITS- M. SHABAT	Legacy Healthcare Financial Services	100.00%	5,396		5,396	38
39	Total		\$ 296,454			\$ 248,886	\$ *	(47,568)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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%	30	\$	30	15	
16	V	30 DEPRECIATION		Legacy Real Properties	100.00%	4,073		4,073	16	
17	V	32 INTEREST EXPENSE		Legacy Real Properties	100.00%	3,404		3,404	17	
18	V	33 REAL ESTATE TAXES		Legacy Real Properties	100.00%	3,590		3,590	18	
19	V								19	
20	V	34 RENT	10,748	Legacy Real Properties	100.00%			(10,748)	20	
21	V								21	
22	V								22	
23	V								23	
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total		\$ 10,748				\$	11,096	\$ * 348	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10 NURSING CONSULTANT	54,000	Progressive Healthcare Consulting	100.00%	11,154	\$ (42,846)
16	V	12 CLERGY SALARY		Progressive Healthcare Consulting	100.00%	736	736
17	V	12 ADMISSIONS SALARY		Progressive Healthcare Consulting	100.00%	5,275	5,275
18	V	15 EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	295	295
19	V	17 ADMIN SALARY- NON OWNER		Progressive Healthcare Consulting	100.00%	15,758	15,758
20	V	19 PROFESSIONAL FEES		Progressive Healthcare Consulting	100.00%	359	359
21	V	20 FEES, SUBSCRIPTIONS		Progressive Healthcare Consulting	100.00%	30	30
22	V	21 CLERICAL & GENERAL		Progressive Healthcare Consulting	100.00%	1,948	1,948
23	V	24 SEMINARS		Progressive Healthcare Consulting	100.00%	67	67
24	V	27 AUTO AND TRAVEL		Progressive Healthcare Consulting	100.00%	754	754
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		\$ 54,000			\$ 36,377	\$ * (17,623)

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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.

SEE ACCOUNTANTS' COMPILATION REPORT

**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.

SEE ACCOUNTANTS' COMPILATION REPORT

**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.

SEE ACCOUNTANTS' COMPILATION REPORT

**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.

SEE ACCOUNTANTS' COMPILATION REPORT

**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.

SEE ACCOUNTANTS' COMPILATION REPORT

**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.

SEE ACCOUNTANTS' COMPILATION REPORT

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	CHAIM RAJCHENBACH	34.3750%	ASTORIA PLACE LIVING AND REHABILITATION CENTER,LLC	CHICAGO	ELMBROOK PROPERTIES	ELMHURST	BUILDING CO	1
2	MENACHEM SHABAT	34.3750%	LAKEFRONT NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO	LEGACY REAL PROPERTIES, I	LINCOLNWOOD	BUILDING CO	2
3	YOSEF AND NAOMI RAJCHENBACH	3.1250%	PARK VILLA NURSING AND REHABILITATION CENTER,LLC	MELROSE PARK	LEGACY HEALTHCARE & FINA	LINCOLNWOOD	HOME OFFICE / BOOKKEE	3
4	AVROHOM AND CHAVA RAJCHENBACH	3.1250%	PETERSON PARK ASSOCIATES LIMITED PARTNERSHIP	CHICAGO	LIFELINE AMBULANCE, LLC	CHICAGO	AMBULANCE	4
5	PINCHAS AND NAHMA SCHWARTZ	3.1250%	THE GROVE AT LINCOLN PARK LIVING AND REHAB CENTER,LLC	CHICAGO	PROGRESSIVE HEALTHCARE	LINCOLNWOOD	NURSING	5
6	JACK RAJCHENBACH FAMILY TRUST	3.1250%	THE GROVE NORTH LIVING AND REHAB CENTER,LLC	SKOKIE	REMED SERVICES LLC	LINCOLNWOOD	DNE SALES	6
7	RONALD SHABAT	15.6250%	THE GROVE OF EVANSTON,LLC	EVANSTON				7
8	SHLOMO ZALMAN AND CHAVA BUSEL	3.1250%	THE GROVE OF LAGRANGE PARK,LLC	LAGRANGE PARK				8
9			WINDSOR PARK	CHICAGO				9
10			CHALET LIVING	CHICAGO				10
11			THE GROVE AT THE LAKE	ZION				11
12			THE GROVE OF NORTHBROOK	NORTHBROOK				12
13			THE VILLA AT EVERGREEN	EVERGREEN PARK				13
14			WARREN BARR	CHICAGO				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 & ID Number

Elmbrook Nursing

# 0051177

Report Period Beginning:

01/01/13

Ending:

12/31/13

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 & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/13 Ending: 12/31/13

## 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	Chaim Rajchenbach	Owner	Administrative	25.00%	See Attached	4.06	8.12%	Mgmt Fees	\$ 16,227	17-07	1
2	Menachem Shabat	Owner	Administrative	25.00%	See Attached	4.06	8.12%	Mgmt Fees	16,227	17-07	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 32,454		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: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	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:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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

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	2	FOOD	AVAIL. BED DAYS	809,780	17	\$ 271	\$ 65,700	\$ 22	1
2	3	HOUSEKEEPING WAGES	AVAIL. BED DAYS	809,780	17	12,745	65,700	1,034	2
3	3	HOUSEKEEPING SUPPLIES	AVAIL. BED DAYS	809,780	17	1,546	65,700	125	3
4	5	UTILITIES	AVAIL. BED DAYS	809,780	17	16,531	65,700	1,341	4
5	6	GROUNDS & MAINTENANCE	AVAIL. BED DAYS	809,780	17	45,337	65,700	3,678	5
6	17	MANAGEMENT FEES	AVAIL. BED DAYS	809,780	17		65,700		6
7	19	PROFESSIONAL FEES	AVAIL. BED DAYS	809,780	17	115,181	65,700	9,345	7
8	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	809,780	17	7,563	65,700	614	8
9	21	CLERICAL & GENERAL WAG	AVAIL. BED DAYS	809,780	17	1,700,817	1,700,817	137,993	9
10	21	CLERICAL & GENERAL OTH	AVAIL. BED DAYS	809,780	17	144,929	65,700	11,759	10
11	24	SEMINARS	AVAIL. BED DAYS	809,780	17	17,652	65,700	1,432	11
12	26	INSURANCE	AVAIL. BED DAYS	809,780	17	15,170	65,700	1,231	12
13	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	809,780	17	289,128	65,700	23,458	13
14	27	EMP BEN- OWNERS	AVAIL. BED DAYS	809,780	17		65,700		14
15	30	DEPRECIATION	AVAIL. BED DAYS	809,780	17	35,039	65,700	2,843	15
16	32	INTEREST	AVAIL. BED DAYS	809,780	17	242	65,700	20	16
17	34	RENT	AVAIL. BED DAYS	809,780	17	132,473	65,700	10,748	17
18									18
19									19
20									20
21	17	MANAGEMENT FEES- C. RAJ	AVG HOURS WKD	50	17	200,000	4	16,227	21
22	17	MANAGEMENT FEES- M. SH	AVG HOURS WKD	50	17	200,000	4	16,227	22
23	27	HEALTH INSURANCE/BENE	AVG HOURS WKD	50	17	66,502	4	5,396	23
24	27	HEALTH INSURANCE/BENE	AVG HOURS WKD	50	17	66,502	4	5,396	24
25	TOTALS					\$ 3,067,628	\$ 1,713,563	\$ 248,886	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmbrook Nursing

# 0051177

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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

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	20	DUES & SUBSCRIPTIONS	AVAIL. BED DAYS	809,780	17	368	65,700	30	1
2	30	DEPRECIATION	AVAIL. BED DAYS	809,780	17	50,196	65,700	4,073	2
3	32	INTEREST EXPENSE	AVAIL. BED DAYS	809,780	17	41,954	65,700	3,404	3
4	33	REAL ESTATE TAXES	AVAIL. BED DAYS	809,780	17	44,250	65,700	3,590	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				\$ 136,768	\$		\$ 11,096	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmbrook Nursing

# 0051177 Report Period Beginning: 01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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

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	NURSING SALARIES	AVAIL. BED DAYS	550,071	11	93,385	93,385	65,700	11,154	1
2	12	CLERGY SALARY	AVAIL. BED DAYS	550,071	11	6,165	6,165	65,700	736	2
3	12	ADMISSIONS SALARY	AVAIL. BED DAYS	550,071	11	44,165	44,165	65,700	5,275	3
4	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	550,071	11	2,467		65,700	295	4
5	17	ADMIN SALARY- NON OWNE	AVAIL. BED DAYS	550,071	11	131,937	131,937	65,700	15,758	5
6	19	PROFESSIONAL FEES	AVAIL. BED DAYS	550,071	11	3,003		65,700	359	6
7	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	550,071	11	250		65,700	30	7
8	21	CLERICAL & GENERAL	AVAIL. BED DAYS	550,071	11	16,314		65,700	1,948	8
9	24	SEMINARS	AVAIL. BED DAYS	550,071	11	560		65,700	67	9
10	27	AUTO AND TRAVEL	AVAIL. BED DAYS	550,071	11	6,314		65,700	754	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					\$ 304,561	\$ 275,653		\$ 36,377	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmbrook Nursing

# 0051177 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	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: 01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	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: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	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: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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					\$	\$		\$	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: 01/01/13 Ending: 12/31/13

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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:

01/01/13

Ending:

12/31/13

**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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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	Greystone		X	Mortgage Note			\$	\$ 13,413,146			\$ 357,103					
2																
3																
4																
5																
<b>Working Capital</b>																
6	The Private Bank		X	Line of Credit				1,300,000			5,424					
7	Allocated from Legacy Financ. Serv.		X								20					
8	See Supplemental Schedule										3,404					
9	<b>TOTAL Facility Related</b>						\$	\$ 14,713,146			\$ 365,951					
<b>B. Non-Facility Related*</b>																
10	Interest Income		X								(7,020)					
11	Interest Income - Bldg Co		X								(157)					
12																
13																
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (7,177)					
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 14,713,146			\$ 358,774					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 119,906 Line # 36

\* 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 & ID Number

Elmbrook Nursing

# 0051177

Report Period Beginning:

01/01/13

Ending:

12/31/13

**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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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							\$	\$			\$					
2																
3																
4																
5																
6																
7	<b>TOTAL Long-Term</b>															
	<b>Working Capital</b>															
8	Allocated from Legacy Real Properties	X					\$	\$			\$ 3,404					
9																
10																
11																
12																
13																
14	<b>TOTAL Working Capital</b>										3,404					
	<b>B. Non-Facility Related*</b>															
15							\$	\$			\$					
16																
17																
18																
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

1. Real Estate Tax accrual used on 2012 report.		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>	\$	<b>60,262</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>68,759</b>	2
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>8,497</b>	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>58,529</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>67,026</b>	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2008 _____	8	<b>FOR BHF USE ONLY</b>	
		2009 _____	9		
		2010 <u>57,682</u>	10	13	FROM R. E. TAX STATEMENT FOR 2012 \$ 13
		2011 <u>63,434</u>	11	14	PLUS APPEAL COST FROM LINE 5 \$ 14
		2012 <u>65,169</u>	12	15	LESS REFUND FROM LINE 6 \$ 15
<b>2013 Accrual: \$65,169 x 0.90 = \$58,529</b>				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
<b>Allocated from Legacy Real Properties: \$3,590</b>					

## 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

## 2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Elmbrook Nursing COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0051177

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2012 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 2012.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>03-26-207-022</u>	<u>Long Term Care Facility</u>	\$ <u>5,127.58</u>	\$ <u>5,127.58</u>
2. <u>03-26-207-025</u>	<u>Long Term Care Facility</u>	\$ <u>60,041.70</u>	\$ <u>60,041.70</u>
3. <u>See Attached</u>	<u>See Attached</u>	\$ <u>44,384.14</u>	\$ <u>3,601.02</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>109,553.42</u></u>	\$ <u><u>68,770.30</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?      X   YES                  NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.  
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

**PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.**



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:

01/01/13 Ending:

12/31/13

**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>\$ 606,331</u>	1
2	<u>Allocated from Legacy Real Properties</u>			<u>6,638</u>	2
3	<b>TOTALS</b>	<b>67,000</b>		<b>\$ 612,969</b>	3

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	\$ 7,403,102	\$ 132,829	35	\$ 211,517	\$ 78,688	\$ 637,926	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*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					57,112	(57,112)		67
68		111,849		3,754	4,647	893	10,928	68
69				461,121		(461,121)		69
70		\$ 7,514,951	\$ 654,816		\$ 216,164	\$ (438,652)	\$ 648,854	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:

01/01/13

Ending:

12/31/13

**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>		\$ 7,514,951	\$ 654,816		\$ 216,164	\$ (438,652)	\$ 648,854	1
2	Sprinklers - Systems Piping #2354	2011	6,826		20	171	171	512	2
3	Remodeling- Demolish Walls, New Walls, Paint	2011	4,650		20	116	116	349	3
4	3Rd Floor Bathrooms - Plumbing, Paint, Tile	2011	7,680		20	384	384	1,152	4
5	Replace Compressor On Air Conditioning Unit	2011	20,565		20	1,028	1,028	3,085	5
6	Replace Lining For Cooling Tower	2011	3,960		20	198	198	594	6
7	New Phone System	2011	6,440		20	322	322	966	7
8	Resident Rooms - Built In Furniture/Drywall/Wallpaper/Paint/Bas	2011	74,419		20	3,721	3,721	11,163	8
9	Sliding Door/Entrance	2011	5,123		20	256	256	768	9
10	Interior Signage	2011	9,825		20	491	491	1,474	10
11	Exterior Signage	2011	13,270		20	664	664	1,991	11
12	Electrical - Phone Jack Intallation/Low Voltage/Duplex Outlets	2011	56,290		20	2,815	2,815	8,444	12
13	Land Improvements - Paint Fence, Paving	2011	52,484		20	2,624	2,624	7,873	13
14	Project A - Lobby - Tiling/Crown Molding/Window/Wall Covering	2011	31,193		20	1,560	1,560	4,679	14
15	Project B - 1St Floor Corridor - Handrails/Flooring/Tiling/Wallpa	2011	103,292		20	5,165	5,165	15,494	15
16	Project C - 1St Floor Resident Rooms - New Fixtures/Built In Head	2011	29,734		20	1,487	1,487	4,460	16
17	Project D - 2Nd Floor Resident Rooms - Light Fixtures/Headboard	2011	57,548		20	2,877	2,877	8,632	17
18	Project E - 2Nd Floor Therapy Rooms - Dividing Wall/Wallpaper/	2011	40,936		20	2,047	2,047	6,140	18
19	Project F - 2Nd Floor Therapy Bathrooms - Flooring/Fixtures	2011	5,709		20	285	285	856	19
20	Project G - 3Rd Floor Resident Rooms - Light Fixtures/Paint/Wind	2011	25,239		20	1,262	1,262	3,786	20
21	Project H - Front Offices - Flooring/Paint/Window	2011	17,943		20	897	897	2,692	21
22	Project I - Elevator - Cab Systems	2011	15,108		20	755	755	2,266	22
23	Project J - 1St Floor Nurses Station - Charting Unit/Railing/Tiling/	2011	13,307		20	665	665	1,996	23
24	Project K - Resident Bathrooms - Flooring/Painting	2011	8,315		20	416	416	1,247	24
25	Project L - 2Nd Floor Nurses Station - Nurses Station/Charting Un	2011	11,652		20	583	583	1,748	25
26	Project M - 2Nd Floor Dining Room - Flooring/Wallcovering/Wind	2011	24,849		20	1,242	1,242	3,727	26
27	Project N - 3Rd Floor Nurses Station - Nurses Station/Charting Un	2011	11,652		20	583	583	1,748	27
28	Project O - 3Rd Floor Corridor - Flooring/Cove Base	2011	33,005		20	1,650	1,650	4,951	28
29	Project P - 3Rd Floor Dining Room - Flooring/Molding/Wallpaper/	2011	36,984		20	1,849	1,849	5,548	29
30	Project Q - 2Nd Floor Corridor - Tiling/Flooring/Crown Molding/	2011	65,334		20	3,267	3,267	9,800	30
31	Wallpaper, Drywall, Paint	2011	2,800		20	140	140	420	31
32	Air Conditioning Unit	2011	4,250		20	213	213	638	32
33	Corner Guards, Lighting, Signage, Wallpaper	2011	4,176		20	209	209	626	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,319,509	\$ 654,816		\$ 256,105	\$ (398,711)	\$ 768,677	34

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:

01/01/13

Ending:

12/31/13

**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 12B, Carried Forward</b>		\$ 8,319,509	\$ 654,816		\$ 256,105	\$ (398,711)	\$ 768,677	1
2	Wallpaper, Paint, Locks, Power Outlets	2011	5,325		20	266	266	799	2
3	Wallpaper, Paint, Baseboards	2011	5,100		20	255	255	765	3
4	Exterior Caulking	2011	5,500		20				4
5	Front Entrance - Fix Damaged Floor, Paint	2011	2,950		20				5
6	Air Handler Repair	2011	2,609		20				6
7	Demolish And Renovate Basement Room/Drywall/Paint/Electric/F	2011	5,750		20				7
8	Demolition: Remove All Damaged Drywall. Rough Carpentry: Rep	2012	36,875		20	1,844	1,844	2,766	8
9	Wallcovering Supply 120 Yrds - Retreat Glacier, Wallcovering Sur	2012	4,210		20	211	211	298	9
10	Water Based Adhesive And A 60Mil Sinfle Ply Ib Decking Shield. I	2012	14,560		20	728	728	849	10
11	26 Door Locks, Renovate Basement Staff Bathroom And Build Nev	2012	8,625		20	431	431	503	11
12	Staff Office Repair: Build New Partion Wall, Remove Wall By Stor	2012	11,850		20	593	593	691	12
13	Add 4"-6" Of Compacted Rock Base, Install New Patio Of Holland	2012	4,025		20	201	201	218	13
14	Replace 68 Lavatory Faucets, Install All New Water Supply Hoses	2012	10,200		20	510	510	680	14
15	Hot Water Boiler Replacement.	2012	12,900		20	645	645	1,236	15
16	Trane Twin Screw Chiller Unit.	2012	104,726		20	5,236	5,236	9,600	16
17	Fan Belt, Electrical Damper Motor, Commercial Service Call, Help	2012	3,926		20	196	196	278	17
18	6 Gaskets	2012	4,440		20	222	222	333	18
19	Hose, Valve, Belt, Soil, Ect.....	2012	2,796		20	140	140	186	19
20	Elevator Ceiling, New Lighting System.	2012	3,716		20	186	186	356	20
21	New Tiles - Vinyl	2012	7,050		20	353	353	558	21
22	Railing Bars For The Existing Staircase, Additional Bars	2012	6,950		20	348	348	521	22
23	Corridor Repair, Cubicle Curtains, Signage & Installation	2012	6,153		20	308	308	461	23
24	Corridor, Dining Room-Wallpaper	2013	5,154		20	945	945	945	24
25	Wash Pump & Gasket Installation	2013	3,244		20	541	541	541	25
26	Furnish And Install Wanderguard System	2013	6,175		20	103	103	103	26
27	Offices By Activity And Dining Room-Walls, Ceiling Tiles, Light F	2013	5,805		20	290	290	290	27
28	Relocated 2" Main And Installed Concealed Pendant Heads, Lowe	2013	5,952		20	248	248	248	28
29	Lower Level Corridors-Flooring, Plank-Washed Teak Tick Surfac	2013	12,214		20	509	509	509	29
30	Fire Damper	2013	3,213		20	94	94	94	30
31	Landscape Irrigation System	2013	10,500		20	306	306	306	31
32	Fire Dampers, X6	2013	4,194		20	105	105	105	32
33	Lower Level Corridors-Railings, Corner Guard	2013	5,805		20	145	145	145	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 8,652,002	\$ 654,816		\$ 272,062	\$ (382,754)	\$ 793,063	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:

01/01/13

Ending:

12/31/13

**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 12C, Carried Forward		\$ 8,652,002	\$ 654,816		\$ 272,062	\$ (382,754)	\$ 793,063	1
2	Lower Level Corridors- Flooring, Contour Plank, Contour Stone, etc	2013	9,344		20	78	78	78	2
3	Landscaping- Stripped And Repairs Lawn, Installed Cubic Yards	2013	35,370		20	1,769	1,769	1,769	3
4	Dining Rm And Hallway - Drywall, Wallpaper, Door, Railing	2013	48,957		20	2,448	2,448	2,448	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)		\$ 8,745,672	\$ 654,816		\$ 276,356	\$ (378,460)	\$ 797,357	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:

01/01/13

Ending:

12/31/13

**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		\$ 8,745,672	\$ 654,816		\$ 276,356	\$ (378,460)	\$ 797,357	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		\$ 8,745,672	\$ 654,816		\$ 276,356	\$ (378,460)	\$ 797,357	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									9
10									10
11									11
12									12
13	<b>Additional Depreciation</b>			57,112			(57,112)		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

Facility Name & ID Number Elmbrook Nursing

# 0051177

Report Period Beginning:

01/01/13

Ending:

12/31/13

**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 (12F & 12G lines 1 thru 33)	\$	\$ 57,112		\$	\$ (57,112)	\$	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>Related Party Information</b>			\$		\$				\$		\$		\$		1
2	<b>Buildings:</b>															2
3	Allocated from Legacy Real Properties	2009		51,427		1,714		20		1,714				1,714		3
4																4
5																5
6																6
7																7
8	<b>Leasehold Information</b>															8
9	Allocated from Legacy Healthcare Financial Services	2012		2,314		243		20		116		(127)		231		9
10	Allocated from Legacy Healthcare Financial Services	2013		7,400		778		20		370		(408)		370		10
11																11
12	Allocated from Legacy Real Properties	2009		29,205		730		20		1,460		730		5,476		12
13	Allocated from Legacy Real Properties	2010		8,881		289		20		356		67		1,244		13
14	Allocated from Legacy Real Properties	2011		12,622				20		631		631		1,893		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

Facility Name & ID Number **Elmbrook Nursing**

# **0051177**

Report Period Beginning:

**01/01/13**

Ending:

**12/31/13**

**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 Continued</b>		\$	\$		\$	\$	\$	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 (12H &amp; 12I lines 1 thru 33)</b>		\$ <b>111,849</b>	\$ <b>3,754</b>		\$ <b>4,647</b>	\$ <b>893</b>	\$ <b>10,928</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 2,709,802	\$ 3,263	\$ 459,629	\$ 456,366	10	\$ 1,483,778	71
72	Current Year Purchases	24,719	903	2,194	1,291	10	2,194	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,734,521	\$ 4,166	\$ 461,823	\$ 457,657		\$ 1,485,973	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)	\$ 12,093,163	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 658,982	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 738,180	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 79,197	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,283,329	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

Facility Name & ID Number Elmbrook Nursing

# 0051177

Report Period Beginning: 01/01/13

Ending: 12/31/13

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	<b>TOTAL</b>				\$ _____			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. \_\_\_\_\_ /2014 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

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: \$ 7,171 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	<b>TOTAL</b>		\$ _____	\$ _____	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	SUM OF line 9, col. 1 and 2 (e)	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
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		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units	Cost			Units	Cost									
1	Licensed Occupational Therapist	39 - 03	hrs	\$				\$	363,482	\$					\$	363,482	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs						135,928							135,928	2
3	Licensed Recreational Therapist		hrs														3
4	Licensed Physical Therapist	39 - 03	hrs						631,426							631,426	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							239,202						239,202	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>								37,528	57,455						94,983	13
14	<b>TOTAL</b>			\$				\$	1,168,364	\$	296,657			\$	1,465,021		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: 01/01/13 Ending: 12/31/13  
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/13 (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	\$ 136,299	\$ 386,244	1
2	Cash-Patient Deposits	10,499	10,499	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	3,175,368	3,175,368	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	102,608	102,608	6
7	Other Prepaid Expenses	5,910	139,131	7
8	Accounts Receivable (owners or related parties)	1,481,817	1,481,817	8
9	Other(specify): <u>See Attached Schedule</u>	180,536	561,283	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 5,093,037	\$ 5,856,950	10
<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		5,180,335	14
15	Leasehold Improvements, at Historical Cost	458,991	1,129,122	15
16	Equipment, at Historical Cost	2,188,711	2,203,711	16
17	Accumulated Depreciation (book methods)	(1,306,690)	(1,888,650)	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	3,690,000	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 5,031,012	\$ 11,624,018	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 10,124,049	\$ 17,480,968	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 576,071	\$ 576,072	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	68	68	28
29	Short-Term Notes Payable	1,300,000	1,300,000	29
30	Accrued Salaries Payable	547,521	547,521	30
31	Accrued Taxes Payable (excluding real estate taxes)	55,062	55,062	31
32	Accrued Real Estate Taxes(Sch.IX-B)	44,403	58,529	32
33	Accrued Interest Payable		29,397	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>	706,523	64,089	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 3,229,648	\$ 2,630,738	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		13,413,146	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 13,413,146	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,229,648	\$ 16,043,884	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 6,894,401	\$ 1,437,084	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 10,124,049	\$ 17,480,968	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>6,584,210</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Period Workers Compensation</b>	(13,805)	<b>3</b>
<b>4</b>	<b>Prior Period Management Fees</b>	(33,035)	<b>4</b>
<b>5</b>	<b>Rounding</b>	(3)	<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>6,537,367</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	1,357,034	<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	(1,000,000)	<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>357,034</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>6,894,401</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	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 12,173,617	1
2	Discounts and Allowances for all Levels	(744,892)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 11,428,725</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,248,652	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 2,248,652</b>	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	241,109	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,083	19
20	Radiology and X-Ray	33,845	20
21	Other Medical Services	181	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 279,218</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	7,220	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 7,220</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	7,504	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 7,504</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 13,971,319</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,681,416	31
32	Health Care	4,236,104	32
33	General Administration	2,546,775	33
<b>B. Capital Expense</b>			
34	Ownership	1,474,939	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	2,298,750	35
36	Provider Participation Fee	376,301	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>\$ 12,614,285</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>1,357,034</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 1,357,034</b>	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 6,642,843	44
45	Private Pay - Net Inpatient Revenue	992,883	45
46	Medicare - Net Inpatient Revenue	3,467,927	46
47	Other-(specify) <u>Veteran</u>	214,346	47
48	Other-(specify) <u>Insurance</u>	110,726	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 11,428,725</b>	49

\* 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.

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

**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name & ID Number Elmbrook Nursing

# 0051177

Report Period Beginning: 01/01/13

Ending:

12/31/13

**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	2,145	2,335	\$ 102,796	\$ 44.02	1
2	Assistant Director of Nursing	2,037	2,214	81,998	37.04	2
3	Registered Nurses	26,125	28,881	988,625	34.23	3
4	Licensed Practical Nurses	27,874	29,496	689,498	23.38	4
5	CNAs & Orderlies	96,330	104,179	1,306,565	12.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,777	11,731	218,620	18.64	8
9	Activity Director	1,943	2,086	40,370	19.35	9
10	Activity Assistants	7,583	8,255	144,511	17.51	10
11	Social Service Workers	5,605	6,081	94,591	15.56	11
12	Dietician					12
13	Food Service Supervisor	2,005	2,054	52,258	25.44	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,982	28,404	306,824	10.80	15
16	Dishwashers					16
17	Maintenance Workers	3,786	4,404	128,994	29.29	17
18	Housekeepers	17,314	19,169	246,454	12.86	18
19	Laundry	5,703	6,456	88,054	13.64	19
20	Administrator	2,016	2,360	136,740	57.94	20
21	Assistant Administrator	1,672	1,809	24,100	13.32	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	22,241	24,175	304,359	12.59	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,025	2,190	68,974	31.49	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,714	1,866	36,084	19.34	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,064	2,160	49,964	23.13	33
34	TOTAL (lines 1 - 33)	266,941	290,305	\$ 5,110,379 *	\$ 17.60	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	383	\$ 17,821	01-03	35
36	Medical Director	Monthly	36,100	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	69,500	10-03	38
39	Pharmacist Consultant	Monthly	9,687	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	183	1,830	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	15	885	12-03	45
46	Other(specify)				46
47	Clergy	Monthly	4,451	12-03	47
48	MDS Consultant	Monthly	62,977	10-03	48
49	TOTAL (lines 35 - 48)	581	\$ 203,251		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. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Abraham Mathew (1/1/13 - 2/15/13)	Administrator	0.00%	\$ 35,858	Workers' Compensation Insurance	\$ 146,139	IDPH License Fee	\$ 3,980	
Mark Murphey (2/25/13 - 12/31/13)	Administrator	0.00%	100,881	Unemployment Compensation Insurance	103,359	Advertising: Employee Recruitment	10,181	
Bianca Lopez (1/1/13 - 9/13/13)	Assistant Admin	0.00%	24,100	FICA Taxes	379,463	Health Care Worker Background Check		
				Employee Health Insurance	109,262	(Indicate # of checks performed <u>280</u> )	5,469	
				Employee Meals	45,727	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	13,124	
				Union Pension	66,599	License and Permits	2,660	
				Employee Physical Exam	2,611	Allocated from Legacy Financial	614	
				Other Employee Benefits	24,534	Allocated from Legacy Real Prop	30	
						See Supplemental Schedule	30	
						Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 160,840	TOTAL (agree to Schedule V, line 22, col.8)	\$ 877,694	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 36,088	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Chaim Rajchenbach - Management Fees			\$ 16,227				Out-of-State Travel	\$
Menachem Shabat - Management Fees			16,227					
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 32,454	TOTAL		\$	Seminar Expense	4,807
							Allocated from Legacy Financial	1,432
							Allocated from Progressive HC	67
							Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 391,698				TOTAL	\$ 6,306

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
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14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmbrook Nursing# 0051177

Report Period Beginning:

01/01/13

Ending:

12/31/13**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. IL Council on Long Term Care \$19,061
- (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. \$ 66,381 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 376,301  
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.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (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. \$ 45,727 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.