FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0040741

Facility Name: DEERBROOK CARE CENTRE

Address: 306 NORTH LARKIN AVENUE (Number) JOLIET (City) 60435 (Zip Code)

County: WILL

Telephone Number: (815) 744-5560 **Fax #** (815) 744-6914

HFS ID Number:

Date of Initial License for Current Owners: 04/01/1994

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: MICHAEL BRAUN **Telephone Number:** (847) 583-0100 X 126
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MICHAEL C. BRAUN
(Title) CONTROLLER

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	214	Skilled (SNF)	214	78,110	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	214	TOTALS	214	78,110	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,289	1,247	8,085	21,621	8
9	SNF/PED					9
10	ICF	36,406	3,693	1,475	41,574	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,695	4,940	9,560	63,195	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.91%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/1994

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/1994 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 214 and days of care provided 7,587

Medicare Intermediary WPS (WISCONSIN PHYSICIAN SERVICES)

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	306,744	20,620	20,467	347,831		347,831	2,019	349,850			1
2	Food Purchase		341,762		341,762		341,762	(2,251)	339,511			2
3	Housekeeping	204,945	40,269		245,214		245,214	(4,718)	240,496			3
4	Laundry	95,122	30,912	1,390	127,424		127,424	475	127,899			4
5	Heat and Other Utilities			182,975	182,975		182,975		182,975			5
6	Maintenance	120,270	32,504	33,588	186,362		186,362	(1,500)	184,862			6
7	Other (specify):*			25,565	25,565		25,565		25,565			7
8	**TOTAL General Services**	727,081	466,067	263,985	1,457,133		1,457,133	(5,975)	1,451,158			8
	B. Health Care and Programs											
9	Medical Director			58,550	58,550		58,550		58,550			9
10	Nursing and Medical Records	3,060,631	232,119	140,069	3,432,819		3,432,819	10,326	3,443,145			10
10a	Therapy	50,624		9,000	59,624		59,624		59,624			10a
11	Activities	143,356	11,247	2,966	157,569		157,569	347	157,916			11
12	Social Services			549	549		549		549			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,254,611	243,366	211,134	3,709,111		3,709,111	10,673	3,719,784			16
	C. General Administration											
17	Administrative	97,765		474,822	572,587		572,587	(473,964)	98,623			17
18	Directors Fees											18
19	Professional Services			414,274	414,274		414,274	(127,043)	287,231			19
20	Dues, Fees, Subscriptions & Promotions			137,913	137,913		137,913	(109,770)	28,143			20
21	Clerical & General Office Expenses	503,374	47,585	73,876	624,835		624,835	234,973	859,808			21
22	Employee Benefits & Payroll Taxes			789,738	789,738		789,738		789,738			22
23	Inservice Training & Education			2,466	2,466		2,466		2,466			23
24	Travel and Seminar							15,650	15,650			24
25	Other Admin. Staff Transportation			1,390	1,390		1,390		1,390			25
26	Insurance-Prop.Liab.Malpractice			323,417	323,417		323,417	4,616	328,033			26
27	Other (specify):*			237,298	237,298		237,298	(237,298)				27
28	**TOTAL General Administration**	601,139	47,585	2,455,194	3,103,918		3,103,918	(692,836)	2,411,082			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,582,831	757,018	2,930,313	8,270,162		8,270,162	(688,138)	7,582,024			29

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

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

Facility Name & ID#: DEERBROOK CARE CENTRE **#0040741** **Report Period Beginning: 01/01/2010** **Ending: 12/31/2010**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	14,149	
	REPAIRS & MAINTENANCE		6,318	
			0	20,467
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,390	
			0	1,390
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		25,414	
	ELECTRICITY		99,476	
	WATER		58,085	
	CABLE TV - LOBBY		0	
			0	182,975
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		7,332	
	PAINTING & DECORATING		1,206	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		8,118	
	ELEVATOR MAINTENANCE & REPAIR		8,160	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,318	
	FIRE SERVICE		4,454	
			0	
			0	
			0	
			0	33,588
7	**OTHER**			
	SCAVENGER		25,565	
	SECURITY SERVICE		0	
			0	
			0	25,565
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	58,550	58,550

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	3,064	
	PHARMACY CONSULTANT	XVIII B 39-2	18,996	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	113,145	
	PSYCHOLOGIST	XVIII B 46-2	4,864	
	ALZHEIMERS	XVIII B 47-2	0	140,069
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	9,000	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				9,000
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		2,966	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	2,966
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	549	
			0	549
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number DEERBROOK CARE CENTRE **#0040741** **Report Period Beginning: 01/01/2010** **Ending: 12/31/2010**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	474,822	474,822
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	31,429	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	382,845	
			0	414,274
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	79,301	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	17,985	
	EMPLOYEE WANT ADS	XIX F	8,375	
	CONTRIBUTIONS	VI 20 XIX F	3,093	
	DUES & SUBSCRIPTIONS	XIX F	11,533	
	LICENSES & PERMITS	XIX F	3,003	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	887	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	9,271	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,960	
	PATIENT BACKGROUND CHECKS	XIX F	2,505	
				137,913
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		5,046	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	11,162	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		52,386	
	MESSENGER SERVICE		5,282	
			0	73,876

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	345,088	
	UNEMPLOYMENT COMPENSATION	XIX D	55,786	
	WORKERS COMPENSATION INSURANC	XIX D	86,665	
	HOSPITALIZATION INSURANCE	XIX D	284,690	
	EMPLOYEE BENEFITS - OTHER	XIX D	4,984	
	EMPLOYEE PHYSICAL EXAMS	XIX D	1,128	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	11,397	
	CHICAGO HEAD TAX	XIX D	0	
			0	789,738
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,466	
				2,466
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		1,390	
				1,390
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		323,417	
				323,417
27	**OTHER**			
	BAD DEBTS	VI 24	237,298	
				237,298

GRAND TOTAL COLUMN 3 OTHER **2,930,313**

DEERBROOK CARE CENTRE
SCHEDULES
12/31/2010

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

TOTAL FOOD PURCHASE	341,762
LESS SALES TAX	(2,251)
NET FOOD	339,511
TOTAL PATIENT CENSUS	63,195
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	189,585
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	189,585
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	189,585
NET FOOD	339,511
DIVIDE TOTAL MEALS/YEAR	189,585
COST PER MEAL	1.79
TIME EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**
	========

Facility Name & ID Number DEERBROOK CARE CENTRE #0040741 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			104,836	104,836		104,836	191,904	296,740			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,300	1,300		1,300	238,777	240,077			32
33	Real Estate Taxes			98,207	98,207		98,207		98,207			33
34	Rent-Facility & Grounds			792,050	792,050		792,050	(733,762)	58,288			34
35	Rent-Equipment & Vehicles			39,659	39,659		39,659	12,883	52,542			35
36	Other (specify):* STORAGE/MTG INS			2,370	2,370		2,370	22,100	24,470			36
37	TOTAL Ownership			1,038,422	1,038,422		1,038,422	(268,098)	770,324			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		443,078	756,148	1,199,226		1,199,226		1,199,226			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			117,165	117,165		117,165		117,165			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		443,078	873,313	1,316,391		1,316,391		1,316,391			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,582,831	1,200,096	4,842,048	10,624,975		10,624,975	(956,236)	9,668,739			45

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

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(39,843)	30		9
10	Interest and Other Investment Income	(1,300)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,251)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(11,162)	21		18
19	Entertainment	(79,301)	20		19
20	Contributions	(12,364)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(1,089)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(237,298)	27		24
25	Fund Raising, Advertising and Promotional	(17,985)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(887)	20		28
29	Other-Attach Schedule	4,288			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (399,192)		$	30

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 Amount	2 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)	(557,044)	PG 6-6D	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (557,044)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (956,236)		37

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

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

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

DEERBROOK CARE CENTRE

ID# 0040741

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$	6	1
2	VACATION ACCRUAL	2,019	1	2
3	VACATION ACCRUAL	(4,718)	3	3
4	VACATION ACCRUAL	475	4	4
5	VACATION ACCRUAL	(1,500)	6	5
6	VACATION ACCRUAL	15,980	10	6
7	VACATION ACCRUAL	347	11	7
8	VACATION ACCRUAL	858	17	8
9	VACATION ACCRUAL	(5,193)	21	9
10	MEDICARE A CONSULTANT	(2,000)	19	10
11	MEDICARE B BILLING		19	11
12	MEDICARE A BILLING		19	12
13	MARKETING CONSULTANT	(1,980)	19	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	4,288		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	2,019	0	0	0	0	0	0	0	0	0	0	2,019	1
2	Food Purchase	(2,251)	0	0	0	0	0	0	0	0	0	0	(2,251)	2
3	Housekeeping	(4,718)	0	0	0	0	0	0	0	0	0	0	(4,718)	3
4	Laundry	475	0	0	0	0	0	0	0	0	0	0	475	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(1,500)	0	0	0	0	0	0	0	0	0	0	(1,500)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,975)	0	0	0	0	0	0	0	0	0	0	(5,975)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	15,980	0	0	(5,654)	0	0	0	0	0	0	0	10,326	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	347	0	0	0	0	0	0	0	0	0	0	347	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	16,327	0	0	(5,654)	0	0	0	0	0	0	0	10,673	16
	C. General Administration													
17	Administrative	858	0	(237,411)	0	0	(237,411)	0	0	0	0	0	(473,964)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,069)	36,135	141,261	3,081	(302,451)	0	0	0	0	0	0	(127,043)	19
20	Fees, Subscriptions & Promotions	(110,537)	100	228	96	343	0	0	0	0	0	0	(109,770)	20
21	Clerical & General Office Expenses	(16,355)	0	15,536	6,934	228,858	0	0	0	0	0	0	234,973	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	3,062	5,331	7,257	0	0	0	0	0	0	15,650	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	896	2,237	1,483	0	0	0	0	0	0	4,616	26
27	Other (specify):*	(237,298)	0	0	0	0	0	0	0	0	0	0	(237,298)	27
28	**TOTAL General Administration**	(368,401)	36,235	(76,428)	17,679	(64,510)	(237,411)	0	0	0	0	0	(692,836)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(358,049)	36,235	(76,428)	12,025	(64,510)	(237,411)	0	0	0	0	0	(688,138)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(39,843)	224,851	2,076	1,036	3,784	0	0	0	0	0	0	191,904	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,300)	240,077	0	0	0	0	0	0	0	0	0	238,777	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(792,050)	0	1,886	56,402	0	0	0	0	0	0	(733,762)	34
35	Rent-Equipment & Vehicles	0	0	5,993	5,231	1,659	0	0	0	0	0	0	12,883	35
36	Other (specify):*	0	22,100	0	0	0	0	0	0	0	0	0	22,100	36
37	TOTAL Ownership	(41,143)	(305,022)	8,069	8,153	61,845	0	0	0	0	0	0	(268,098)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(399,192)	(268,787)	(68,359)	20,178	(2,665)	(237,411)	0	0	0	0	0	(956,236)	45

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF OWNERS		SEE ATTACHED LIST OF RELATED		DEERBROOK NURSING CENTRE		
		NURSING HOMES			MORTON GROVE	REAL ESTATE
				SEE ATTACHED LIST OF OTHER RELATED		
				ENTITIES		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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	$ 792,050	DEERBROOK NURSING CENTRE		$	$ (792,050)	1
2	V	36	MORTGAGE INSURANCE		" "		22,100	22,100	2
3	V	30	DEPRECIATION - BLDG IMP		" "		224,459	224,459	3
4	V	30	DEPRECIATION - EQPT & FIX.		" "		392	392	4
5	V	32	AMORTIZATION - MTG COST		" "		1,256	1,256	5
6	V	32	MORTGAGE INTEREST		" "		238,821	238,821	6
7	V	32	INTEREST - OTHER		" "				7
8	V	19	ACCOUNTING		" "		26,085	26,085	8
9	V	19	DATA PROCESSING		" "		50	50	9
10	V	20	LICENSES & PERMITS		" "		100	100	10
11	V	19	LEGAL FEES		" "				11
12	V	19	OTHER PROFESSIONAL		" "		10,000	10,000	12
13	V								13
14	Total			$ 792,050			$ 523,263	$ * (268,787)	14

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

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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)	
15	V	19	PROFESSIONAL FEES	$	WITTINGHAM MANAGEMENT ASSOCIATES, LLC		$ 141,261	$ 141,261	15
16	V	20	DUES & SUBSCRIPTIONS		" "		228	228	16
17	V	21	CLERICAL		" "		15,536	15,536	17
18	V	24	TRAVEL		" "		3,062	3,062	18
19	V	26	INSURANCE		" "		896	896	19
20	V	35	RENT - EQPT & VEH		" "		5,993	5,993	20
21	V	17	ADMINISTRATIVE	237,411	" "			(237,411)	21
22	V	30	DEPRECIATION		" "		2,076	2,076	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			$ 237,411			$ 169,052	$ * (68,359)	39

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

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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)	
15	V	10	NURSING	$ 113,145	CARLYLE NURSING ASSOCIATES, LLC		$ 107,491	$ (5,654)	15
16	V	19	PROFESSIONAL FEES		" "		3,081	3,081	16
17	V	20	DUES & SUBSCRIPTIONS		" "		96	96	17
18	V	21	CLERICAL		" "		6,934	6,934	18
19	V	24	TRAVEL		" "		5,331	5,331	19
20	V	26	INSURANCE		" "		2,237	2,237	20
21	V	30	DEPRECIATION		" "		1,036	1,036	21
22	V	34	RENT		" "		1,886	1,886	22
23	V	35	RENT - EQPT & VEH		" "		5,231	5,231	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			$ 113,145			$ 133,323	$ * 20,178	39

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

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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)	
15	V	19	PROFESSIONAL FEES	$ 304,587	THE KENSINGTON GROUP, LLC		$ 2,136	$ (302,451)	15
16	V	20	DUES & SUBSCRIPTIONS		" "		343	343	16
17	V	21	CLERICAL		" "		228,858	228,858	17
18	V	24	TRAVEL		" "		7,257	7,257	18
19	V	26	INSURANCE		" "		1,483	1,483	19
20	V	30	DEPRECIATION		" "		3,784	3,784	20
21	V	34	RENT		" "		56,402	56,402	21
22	V	35	RENT - EQPT & VEH		" "		1,659	1,659	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			$ 304,587			$ 301,922	$ * (2,665)	39

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

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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)	
15	V	17	ADMINISTRATIVE	$ 237,411	CHESTERFIELD, LLC		$	$ (237,411)	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	Total			$ 237,411			$ 0	$ * (237,411)	39

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

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

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

	1 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	19	PROFESSIONAL FEES	PATIENT DAYS	361,812	7	$ 808,776	$	63,195	$ 141,261	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	361,812	7	1,305		63,195	228	2
3	21	CLERICAL	PATIENT DAYS	361,812	7	88,950		63,195	15,536	3
4	24	TRAVEL	PATIENT DAYS	361,812	7	17,533		63,195	3,062	4
5	26	INSURANCE	PATIENT DAYS	361,812	7	5,130		63,195	896	5
6	35	RENT - EQPT & VEHICLES	PATIENT DAYS	361,812	7	34,314		63,195	5,993	6
7	30	DEPRECIATION	PATIENT DAYS	361,812	7	11,887		63,195	2,076	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					$ 967,895	$		$ 169,052	25

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT HOURS	1	1	$ 107,491	$ 107,491	1	$ 107,491	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	552,974	11	26,955		63,195	3,081	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	552,974	11	842		63,195	96	3
4	21	CLERICAL	PATIENT DAYS	552,974	11	60,665		63,195	6,934	4
5	24	TRAVEL	PATIENT DAYS	552,974	11	46,637		63,195	5,331	5
6	26	INSURANCE	PATIENT DAYS	552,974	11	19,567		63,195	2,237	6
7	30	DEPRECIATION	PATIENT DAYS	552,974	11	9,065		63,195	1,036	7
8	34	RENT	PATIENT DAYS	552,974	11	16,500		63,195	1,886	8
9	35	RENT - EQPT & VEH	PATIENT DAYS	552,974	11	45,767		63,195	5,231	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					$ 333,489	$ 107,491		$ 133,323	25

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

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

	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	19	PROFESSIONAL FEES	PATIENT DAYS	552,954	11	$ 18,688	$	63,195	$ 2,136	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	552,954	11	3,004		63,195	343	2
3	21	CLERICAL	PATIENT DAYS	552,954	11	200,775		63,195	22,947	3
4	24	TRAVEL	PATIENT DAYS	552,954	11	63,497		63,195	7,257	4
5	26	INSURANCE	PATIENT DAYS	552,954	11	12,980		63,195	1,483	5
6	30	DEPRECIATION	PATIENT DAYS	552,954	11	33,106		63,195	3,784	6
7	34	RENT	PATIENT DAYS	552,954	11	493,503		63,195	56,402	7
8	35	RENT - EQPT & VEH	PATIENT DAYS	552,954	11	14,513		63,195	1,659	8
9	21	CLERICAL	DIRECT HOURS	1	1	205,911	205,911	1	205,911	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					$ 1,045,977	$ 205,911		$ 301,922	25

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY - DEERBROOK NURSING CENTRE						$	$			$	1
2	BERKADIA		X	MORTGAGE	$61,407.35	12/03	4,775,900	4,390,169	12/38	5.4000	238,821	2
3	BERKADIA		X	LOAN COST	AMORT - 35 YEARS		43,959	35,108			1,256	3
4												4
5												5
	Working Capital											
6	LETTER OF CREDIT FEE		X								1,300	6
7												7
8												8
9	TOTAL Facility Related				$61,407.35		$ 4,819,859	$ 4,425,277			$ 241,377	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,819,859	$ 4,425,277			$ 241,377	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **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.)**

**** 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 DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 92,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 94,807	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,307	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 95,900	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 98,207	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	91,618	8
	2006	89,650	9
	2007	90,172	10
	2008	91,437	11
	2009	94,807	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DEERBROOK CARE CENTRE COUNTY WILL

FACILITY IDPH LICENSE NUMBER 0040741

CONTACT PERSON REGARDING THIS REPORT MICHAEL BRAUN

TELEPHONE (847) 583-0100 X 126 FAX #: (847) 583-8873

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	30-07-07-401-034-0000	NURSING HOME	$ 94,807.30	$ 94,807.30
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 94,807.30	$ 94,807.30

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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).

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	105,000	1975	$ 247,500	1
2	754 BASIS ADJ.		1992	14,443	2
3	TOTALS	105,000		$ 261,943	3

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	214			1975	$ 1,849,704	$ 29,750	35	$ 29,750	$	$ 1,764,925	4
5				1980	168,687		20			168,687	5
6	754 ADJ.			1992	125,584	4,567	27.5	4,567		84,294	6
7	754 ADJ.			2001	29,192	1,061	27.5	1,061		10,618	7
8											8
	Improvement Type**										
9	****RELATED PARTY - DEERBROOK NURSING CENTRE*******										9
10	IMPROVEMENTS			1984	33,823		20			33,823	10
11	IMPROVEMENTS			1986	21,535		20			21,535	11
12	IMPROVEMENTS			1987	78,860	2,868	27.5	2,868		61,280	12
13	IMPROVEMENTS			1988	48,614	1,768	27.5	1,768		35,964	13
14	IMPROVEMENTS			1989	60,430	2,198	27.5	2,198		43,988	14
15	IMPROVEMENTS			1990	30,485	1,108	27.5	1,108		20,469	15
16	IMPROVEMENTS			1991	53,134	1,931	27.5	1,931		34,490	16
17	IMPROVEMENTS			1992	117,363	4,267	27.5	4,267		72,086	17
18	IMPROVEMENTS			1993	29,335	1,067	27.5	1,067		17,571	18
19	IMPROVEMENTS			1993	29,864	1,086	27.5	1,086		15,556	19
20	IMPROVEMENTS			1994	37,711	1,372	27.5	1,372		22,378	20
21	VINYL SLIDER UNITS			1995	3,070	111	27.5	111		1,729	21
22	DOORS			1995	2,564	94	27.5	94		1,439	22
23	ROOF			1996	24,069	875	27.5	875		12,725	23
24	OUR TOWN			1996	74,400	2,705	27.5	2,705		37,985	24
25	ROOF/REMODEL KITCHEN/DUMPSTER/FLOORS			1997	440,180	16,006	27.5	16,006		213,214	25
26	ALZHEIMERS WING CONSTRUCTION			1997	1,590,575	57,839	27.5	57,839		770,574	26
27	OUR TOWN			1998	21,500	782	27.5	782		10,132	27
28	ALZHEIMERS WING CONSTRUCTION-FINAL DRAW			1998	17,009	619	27.5	619		8,012	28
29	DINING ROOM FLOOR - TILES			1998	30,000	1,091	27.5	1,091		14,138	29
30	DOOR ALARM SYSTEMS			1998	24,760	901	27.5	901		11,665	30
31	SPRINKLERS			1998	3,500	127	27.5	127		1,647	31
32	DINING ROOM - WALLPAPER/TILE BASE			1998	14,900	542	27.5	542		6,977	32
33	RENOVATE 2 ROOMS/REPLACE ELEVATOR FLOORS			1998	9,400	342	27.5	342		4,374	33
34	REMODELING OF ELEVATOR - LOBBY			1998	7,050	257	27.5	257		3,256	34
35	LANDSCAPING			1998	2,815	103	27.5	103		1,299	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

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
37	ROOF TOP PTAC UNITS	1998	$ 3,508	$ 128	27.5	$ 128	$	$ 1,624	37
38	DINING & RESIDENT ROOM FLOORS	1998	15,268	555	27.5	555		7,008	38
39	HOT WATER TANK	1998	1,780	65	27.5	65		819	39
40	REMODELING - SHOWER ROOM	1998	3,830	139	27.5	139		1,721	40
41	ASPHALT PARKING LOT & SPEED BUMPS	1998	17,156	624	27.5	624		7,617	41
42	WALLCOVERING/WINDOW TRMTS/TILES	1998	18,635	677	27.5	677		8,275	42
43	REMODELING - RESIDENT ROOMS	1998	37,050	1,347	27.5	1,347		16,220	43
44	WINDOW TREATMENTS/REMODEL RMS	1999	18,066	657	27.5	657		7,857	44
45	FIRE ALARMS & HVAC/CEILING/HALLS/CALL LIGHTS	1999	25,000	909	27.5	909		10,795	45
46	REPAIR & REMODEL HALLWAY/DOOR MONITOR SYS	1999	23,425	852	27.5	852		10,045	46
47	REMODEL ROOMS/DOOR MONITOR SYS	1999	45,989	1,673	27.5	1,673		19,579	47
48	REMODEL RMS/LANDSCAPING	1999	53,572	1,948	27.5	1,948		22,646	48
49	WALLCOVERING/WINDOW TRMTS/TILES	1999	6,950	253	27.5	253		2,919	49
50	REMODELING RMS	1999	16,205	589	27.5	589		6,750	50
51	WALLCOVERING/FLOOR TILES/HANDRAILS	1999	28,464	1,035	27.5	1,035		11,773	51
52	REMODELING RMS	1999	47,115	1,713	27.5	1,713		19,344	52
53	NURSE STATION/ELEVATOR DOOR	1999	18,030	655	27.5	655		7,351	53
54	REMODELING ROOMS/WINDOW TRMTS	1999	170,712	6,208	27.5	6,208		68,539	54
55	FIRE DAMPERS	2000	4,950	180	27.5	180		1,973	55
56	REMODELING - WASHROOMS/MEDICAL & REC. RM	2000	35,550	1,293	27.5	1,293		13,952	56
57	FENCES	2000	3,557	130	27.5	130		1,384	57
58	WALLCOVERING/WINDOW TRMNT - RES & DINING RMS	2000	69,939	2,543	27.5	2,543		26,809	58
59	FIREWALL/RESIDENT ROOM CEILING/TUCKPOINTING	2000	85,160	3,097	27.5	3,097		32,641	59
60	MAGNETIC DOOR/STEAMER	2000	16,334	451	27.5	451		4,757	60
61	HANDRAILS	2000	8,101	295	27.5	295		3,083	61
62	REMODELING - NURSE STATION/CORRIDOR/DINING RM	2000	126,731	4,608	27.5	4,608		48,195	62
63	PTAC UNITS	2000	3,550	130	27.5	130		1,350	63
64	CONCRETE PAVING	2000	11,700	425	27.5	425		4,447	64
65	IRRIGATION SYSTEM & ROOM PLATES	2000	10,425	379	27.5	379		3,932	65
66	DESIGN & BUILD ENABLING GARDEN	2000	19,832	1,322	15	1,322		13,886	66
67	CARPETING/WINDOW TREATMENT	2000	14,549	529	27.5	529		5,444	67
68	PTAC UNITS	2000	3,550	130	27.5	130		1,329	68
69	REMODELING - BREAK ROOM & MEDICATION ROOM	2000	39,886	1,450	27.5	1,450		14,925	69
70	TOTAL (lines 4 thru 69)		$ 5,984,682	$ 172,426		$ 172,426	$	$ 3,915,819	70

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

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12A, Carried Forward		$ 5,984,682	$ 172,426		$ 172,426	$	$ 3,915,819	1
2	SIDEWALK	2000	2,240	81	27.5	81		829	2
3	REMODELING - RESIDENT RMS. LOBBY, MAILROOM	2000	60,826	2,212	27.5	2,212		22,580	3
4	PTAC UNITS	2000	4,644	169	27.5	169		1,724	4
5	WOOD BLINDS FOR OFFICES	2001	3,538	128	27.5	128		1,282	5
6	CUBICLES	2001	8,332	303	27.5	303		3,017	6
7	REMODEL - ALL 2ND FLOOR RESIDENT ROOMS	2001	370,353	13,468	27.5	13,468		134,107	7
8	VERTICAL BLINDS FOR 2ND FLOOR ROOMS	2001	3,847	140	27.5	140		1,394	8
9	CARPETING FIRST FLOOR OFFICES/PLUMBING	2001	8,850	322	27.5	322		3,152	9
10	DROP & CHANGE SPRINKLER HEADS IN CORRIDOR	2001	5,097	186	27.5	186		1,798	10
11	REPAIR CEILING ON FIRST FLOOR	2001	25,000	909	27.5	909		8,825	11
12	REPAIR CORRIDOR IN LAUNDRY AREA	2001	10,000	363	27.5	363		3,471	12
13	TEN TON COMPRESSOR FOR KITCHEN UNIT	2001	4,441	161	27.5	161		1,498	13
14	INSTALL TILE FLOORING IN SERVICE HALLWAY	2002	11,300	411	27.5	411		3,682	14
15	INSTALL ELECTRICAL OUTLETS IN RMS 101 TO 104	2002	8,000	291	27.5	291		2,486	15
16	INSTALL PIPE RUN FR. ELECTRICAL CLOSET TO RM 104	2002	1,186	43	27.5	43		368	16
17	FRIEDRICH 11700 BTU PTAC UNITS - 2	2002	1,337	49	27.5	49		416	17
18	AMANA - PTAC 12000 BTU HEAT & 11700 PTAC UNIT	2002	1,379	50	27.5	50		424	18
19	REPLACE FIRE PANEL	2003	4,500	163	27.5	163		1,249	19
20	2 CANVAS AWNINGS	2003	1,650	110	15	110		784	20
21	RESTRIP AND ASPHALT SEAL PARKING LOT	2003	6,535	435	15	435		3,104	21
22	INSTALLATION OF 4 BATHRM WATER SHUT OFF VALVES	2004	2,360	86	27.5	86		597	22
23	WIRING AND INSTALLATION OF TV'S IN RES. ROOMS	2004	20,700	753	27.5	753		4,988	23
24	CONCRETE WORK DONE TO B WING SIDE WALK	2004	5,540	201	27.5	201		1,317	24
25	REPAIR/REPLACEMENT OF ELECTRICAL LIGHTING	2004	7,350	267	27.5	267		1,748	25
26	INSTALL 80 SOLID CORE, FIRE RATED DOORS	2004	75,115	2,731	27.5	2,731		17,185	26
27	INSTALL NEW ELECTRICAL WIRING & PIPING - 1ST FLR	2004	33,552	1,220	27.5	1,220		7,371	27
28	INSTALLATION OF 20 AMP CIRCUIT IN STORAGE CLOSET	2005	822	29	27.5	29		175	28
29	REMOVED OLD & INSTALLED NEW WATER RECOND. SYS	2005	8,360	304	27.5	304		1,761	29
30	FIRE SPRINKLER SYSTEM	2005	2,060	75	27.5	75		403	30
31	MORTAR WORK & FIRE CAULK - 1ST FLOOR, A,B,C WING								31
32	2ND FLOOR A, B, C, WING, SHORTAGE RM, & DINING RM	2005	9,740	354	27.5	354		1,904	32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,693,336	$ 198,440		$ 198,440	$	$ 4,149,458	34

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

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,693,336	$ 198,440		$ 198,440	$	$ 4,149,458	1
2	DEMOLITION & REMODEL 4 SHOWER ROOMS	2006	321,289	11,684	27.5	11,684		55,009	2
3	DOORS & ALUMINUM DOOR FRAMES	2006	2,150	78	27.5	78		381	3
4	NURSE CALL SYSTEM	2006	4,791	174	27.5	174		733	4
5	NEW PLANTINGS, HEAVY MULCH, PULVERIZED BLACK S	2008	11,513	768	15	768		2,239	5
6	DESIGN TIME - LOBBY, MEDIA CENTER WINDOW TREATI	2008	11,482	417	27.5	417		974	6
7	PURCHASE OF WALL PAPER	2008	50,337	1,830	27.5	1,830		4,881	7
8	SPRINKLER SYSTEM	2008	4,430	161	27.5	161		389	8
9	DIG & INSTALL CLEAN OUT PLUG - SOUTH WING	2008	3,500	127	27.5	127		265	9
10	WALL PAPER & CARPET - NURSING STATION, PHYSICAL	2008	54,165	1,970	27.5	1,970		4,268	10
11	DRYWALL & PAINT - THERAPY ROOM, 40 BATHROOMS	2008	60,000	2,182	27.5	2,182		4,727	11
12	PREP & PAINT - HALLWAYS, NURSES STATIONS, PT RM								12
13	ELEVATOR DOORS & SOFFITS	2009	24,512	2,451	10	2,451		5,281	13
14	RECOVER FOR PIPE FRAME AWNING ON SW, NW, E & SE								14
15	SIDES OF BUILDING	2009	3,375	337	10	337		450	15
16	COMPLETED PHYSICAL THERAPY PLANK	2009	5,361	195	27.5	195		260	16
17									17
18	LABOR & VINYL PLANK FOR CLUBHOUSE FLOORING	2010	5,744	131	27.5	131		131	18
19	7.5 TON GAS ELE HIEF-CARRIER UNIT WITH HEAT	2010	5,318	121	27.5	121		121	19
20	CONSTRUCTION ON A NEW INPATIENT DIALYSIS TRMT	2010							20
21	ROOM - INSTALL DROP CEILINGS, ELECTRICAL &	2010							21
22	PLUMBING WORK, NEW DOORS, CABINETS & COUNTER	2010							22
23	TOPS & INSULATE INTERIOR	2010	193,308	2,637	27.5	2,637		2,637	23
24	REBUILD NURSES STATION & KITCHEN - REMOVE &								24
25	INSTALL NEW COUNTER TOPS, CABINETS, ELECTRICAL								25
26	AND PLUMBING WORK & ELECTRICAL FIXTURES	2010	49,345	673	27.5	673		673	26
27	F&I STRUCTURED WIRING TO SUPPORT WAP								27
28	CONNECTIVITY	2010	7,799	83	27.5	83		83	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,511,755	$ 224,459		$ 224,459	$	$ 4,232,960	34

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

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 640,754	$ 47,474	$ 60,088	$ 12,614		$ 338,272	71
72	Current Year Purchases	83,368	56,513	4,168	(52,345)		4,168	72
73	Fully Depreciated Assets	389,364					389,364	73
74	RELATED PARTY		7,288	7,288				74
75	TOTALS	$ 1,113,486	$ 111,275	$ 71,544	$ (39,731)		$ 731,804	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	NURSING - HOME USE	2003 FORD CLUB WAGON	2007	$ 7,368	$ 849	$ 737	$ (112)	10 YRS	$ 2,948	76
77										77
78										78
79										79
80	TOTALS			$ 7,368	$ 849	$ 737	$ (112)		$ 2,948	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,894,552	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 336,583	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 296,740	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (39,843)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,967,712	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.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

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.	/2011	$
13.	/2012	$
14.	/2013	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 34,186 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18	ADMINISTRATIVE	2007 HONDA ACCORD	300.00	5,473	18
19					19
20					20
21	TOTAL		$ 300.00	$ 5,473	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.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number DEERBROOK CARE CENTRE | STATE OF ILLINOIS # 0040741 | Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 280,473	$		$ 280,473	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			163,204			163,204	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			312,471			312,471	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				298,278		298,278	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	X-RAY, LAB, I.V. THERAPY Other (specify): RENTAL/MED SUPP.	39-2					144,800		144,800	13
14	TOTAL			$		$ 756,148	$ 443,078		$ 1,199,226	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.

STATE OF ILLINOIS

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,861,044	$ 3,820,339	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 237,298)	383,560	383,560	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,955	1,955	5
6	Prepaid Insurance	52,879	161,694	6
7	Other Prepaid Expenses	67,576	67,576	7
8	Accounts Receivable (owners or related parties)	54,623	85,742	8
9	Other(specify): ESCROW DEPOSITS		205,844	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,421,637	$ 4,726,710	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	2,347,567	1,935,545	11
12	Long-Term Investments			12
13	Land		247,500	13
14	Buildings, at Historical Cost		7,353,064	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,094,917	1,094,917	16
17	Accumulated Depreciation (book methods)	(1,000,842)	(5,138,892)	17
18	Deferred Charges		109,415	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		239,990	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,441,642	$ 5,841,539	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,863,279	$ 10,568,249	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 275,701	$ 278,701	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	60,917	60,917	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	189,183	189,183	30
31	Accrued Taxes Payable (excluding real estate taxes)	27,668	27,668	31
32	Accrued Real Estate Taxes(Sch.IX-B)		95,900	32
33	Accrued Interest Payable		19,756	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO LESSOR	456,422		36
37	MANAGEMENT FEES	187,763	187,763	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,197,654	$ 859,888	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,390,169	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,390,169	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,197,654	$ 5,250,057	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,665,625	$ 5,318,192	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,863,279	$ 10,568,249	48

***(See instructions.)**

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,784,711	1
2	Restatements (describe):		2
3	ROUNDING ADJ.	7	3
4	SEC 754 ADJ.	(13,229)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,771,489	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,894,136	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(2,000,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (105,864)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,665,625	24 *

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

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,452,851	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,452,851	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	65,989	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 65,989	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	NET VENDING COMMISSIONS	271	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 271	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,519,111	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,457,133	31
32	Health Care	3,709,111	32
33	General Administration	3,103,918	33
	B. Capital Expense		
34	Ownership	1,038,422	34
	C. Ancillary Expense		
35	Special Cost Centers	1,199,226	35
36	Provider Participation Fee	117,165	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,624,975	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,894,136	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,894,136	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

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

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

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,894	2,086	$ 85,828	$ 41.14	1
2	Assistant Director of Nursing	2,009	2,190	81,034	37.00	2
3	Registered Nurses	30,946	33,456	1,009,972	30.19	3
4	Licensed Practical Nurses	30,127	31,325	769,616	24.57	4
5	CNAs & Orderlies	96,142	100,542	1,047,096	10.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,091	4,286	50,624	11.81	8
9	Activity Director	2,513	2,727	70,435	25.83	9
10	Activity Assistants	6,947	7,311	72,921	9.97	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	3,718	4,211	72,120	17.13	13
14	Head Cook	5,526	5,927	70,130	11.83	14
15	Cook Helpers/Assistants	18,619	19,319	164,494	8.51	15
16	Dishwashers					16
17	Maintenance Workers	3,797	4,428	83,105	18.77	17
18	Housekeepers	17,008	18,480	204,945	11.09	18
19	Laundry	10,716	11,225	95,122	8.47	19
20	Administrator	1,997	2,191	97,765	44.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,865	2,254	69,844	30.99	23
24	Clerical	22,828	25,348	433,530	17.10	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,009	2,306	37,051	16.07	31
32	Other Health C: ALZHEIMER DR	1,981	2,086	30,034	14.40	32
33	Other(specify) SECURITY	3,314	3,568	37,165	10.42	33
34	TOTAL (lines 1 - 33)	268,047	285,266	$ 4,582,831 *	$ 16.07	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	239	$ 14,149	1-3	35
36	Medical Director	588	58,550	9-3	36
37	Medical Records Consultant	44	3,064	10-3	37
38	Nurse Consultant	MONTHLY	113,145	10-3	38
39	Pharmacist Consultant	MONTHLY	18,996	10-3	39
40	Physical Therapy Consultant	24	9,000	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	9	549	12-3	45
46	Other(specify) PSYCHOLOGIST	91	4,864	10-3	46
47			0	10-3	47
48					48
49	TOTAL (lines 35 - 48)	995	$ 222,317		49

C. CONTRACT NURSES

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

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
TAMMY STONEBERGER	ADMINISTRATOR		$ 97,765
	ASST ADMIN		0
	OTHER ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 97,765

B. Administrative - Other

Description	Amount
WITTINGHAM MANAGEMENT ASSOC, LLC	$ 237,411
CHESTERFIELD, LLC	237,411
TOTAL (agree to Schedule V, line 17, col. 3)	$ 474,822
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		414,274
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 414,274

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 86,665
Unemployment Compensation Insurance	55,786
FICA Taxes	345,088
Employee Health Insurance	284,690
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	4,984
EMPLOYEE PHYSICAL EXAMS	1,128
PENSION/PROFIT SHARING PLANS	11,397
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 789,738

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	8,375
Health Care Worker Background Check	1,960
(Indicate # of checks performed 190)	
Patient Background Checks 250	2,505
TRUST/FRANCHISE/CONTRIB/ETC	12,364
MARKETING/ADV/PROMO	98,173
LICENSES/DUES/SUBSCRIPTIONS	14,536
MGMT CO ALLOC	767
TRUST/FRANCHISE/CONTRIB/ETC	(12,364)
Less: Public Relations Expense	(79,301)
Non-allowable advertising	(17,985)
Yellow page advertising	(887)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,143

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	0
RELATED PARTY	15,650
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,650

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	PAINT/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number DEERBROOK CARE CENTRE # 0040741 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILL COUNCIL ON LTC - $18504.78**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **19,035** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **117,165**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

(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.