FOR BHF USE

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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.

I. IDPH License ID Number: 0051177

Facility Name: Elmbrook Nursing

Address: 127 West Diversey (Number) Elmhurst (City) 60126 (Zip Code)

County: Dupage

Telephone Number: (630)530-5225 **Fax #** (630)530-7775

HFS ID Number:

Date of Initial License for Current Owners: 10/1/2010

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
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 01/01/14 to 12/31/14 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)
(Title)

Paid Preparer

(Signed)
(Date)
(Print Name and Title) Kimberley A. Waite, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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 Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 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	176	Skilled (SNF)	176	64,240	1
2		Skilled Pediatric (SNF/PED)			2
3	4	Intermediate (ICF)	4	1,460	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	180	TOTALS	180	65,700	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,920	3,692	10,449	27,061	8
9	SNF/PED					9
10	ICF	27,708	2,914	601	31,223	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,628	6,606	11,050	58,284	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.71%

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 [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 10/01/2010

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/01/2010 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 176 and days of care provided 9,855

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	372,167	34,630	18,476	425,273		425,273		425,273			1
2	Food Purchase		357,460		357,460	(46,516)	310,944	(397)	310,547			2
3	Housekeeping	273,823	33,930	31	307,784		307,784	833	308,617			3
4	Laundry	92,375	23,067		115,442		115,442		115,442			4
5	Heat and Other Utilities			278,120	278,120		278,120	(4,504)	273,616			5
6	Maintenance	82,781	2,222	155,129	240,132		240,132	(14,853)	225,279			6
7	Other (specify):*											7
8	**TOTAL General Services**	821,146	451,309	451,756	1,724,211	(46,516)	1,677,695	(18,921)	1,658,774			8
	B. Health Care and Programs											
9	Medical Director			47,500	47,500		47,500		47,500			9
10	Nursing and Medical Records	3,468,923	244,552	106,367	3,819,842		3,819,842	(77,183)	3,742,659			10
10a	Therapy	243,477	150	3,906	247,533		247,533		247,533			10a
11	Activities	224,356	13,681		238,037		238,037	340	238,377			11
12	Social Services	123,068		9,216	132,284		132,284	3,913	136,197			12
13	CNA Training											13
14	Program Transportation			2,598	2,598		2,598		2,598			14
15	Other (specify):*							155	155			15
16	**TOTAL Health Care and Programs**	4,059,824	258,383	169,587	4,487,794		4,487,794	(72,775)	4,415,019			16
	C. General Administration											
17	Administrative	121,090		24,098	145,188		145,188	6,521	151,709			17
18	Directors Fees											18
19	Professional Services			482,747	482,747		482,747	(276,940)	205,807			19
20	Dues, Fees, Subscriptions & Promotions			210,901	210,901		210,901	(187,912)	22,989			20
21	Clerical & General Office Expenses	413,189	7,645	475,387	896,221		896,221	(292,285)	603,936			21
22	Employee Benefits & Payroll Taxes			943,097	943,097	46,516	989,613		989,613			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,907	3,907		3,907	487	4,394			24
25	Other Admin. Staff Transportation			10,976	10,976		10,976		10,976			25
26	Insurance-Prop.Liab.Malpractice			178,242	178,242		178,242	14,021	192,263			26
27	Other (specify):*							33,300	33,300			27
28	**TOTAL General Administration**	534,279	7,645	2,329,355	2,871,279	46,516	2,917,795	(702,808)	2,214,987			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,415,249	717,337	2,950,698	9,083,284		9,083,284	(794,503)	8,288,781			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Elmbrook Nursing #0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			487,478	487,478		487,478	279,705	767,183			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,203	13,203		13,203	338,448	351,651			32
33	Real Estate Taxes			63,436	63,436		63,436	71,228	134,664			33
34	Rent-Facility & Grounds			938,892	938,892		938,892	(938,892)				34
35	Rent-Equipment & Vehicles			13,744	13,744		13,744	29	13,773			35
36	Other (specify):*			369,000	369,000		369,000	(302,930)	66,070			36
37	**TOTAL Ownership**			1,885,753	1,885,753		1,885,753	(552,412)	1,333,341			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		316,477	1,143,204	1,459,681		1,459,681		1,459,681			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			398,377	398,377		398,377		398,377			42
43	Other (specify):*	53,533		794,493	848,026		848,026	(848,026)	(0)			43
44	**TOTAL Special Cost Centers**	53,533	316,477	2,336,074	2,706,084		2,706,084	(848,026)	1,858,058			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,468,782	1,033,814	7,172,525	13,675,121		13,675,121	(2,194,941)	11,480,180			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 Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	(6,163)	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	83,629	30		9
10	Interest and Other Investment Income	(10,742)	32		10
11	Discounts, Allowances, Rebates & Refunds	(12,579)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(405)	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	(4,628)	21		18
19	Entertainment				19
20	Contributions	(102,397)	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	(281,212)	21		24
25	Fund Raising, Advertising and Promotional	(65,806)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(7,182)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,404,610)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,812,095)		$	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)	(382,846)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (382,846)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,194,941)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Elmbrook Nursing

ID# 0051177

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Capitalized R&M	$ (13,575)	06	1
2	Additional R&M	18,573	06	2
3	Veterans Expense	(22,933)	10	3
4	Sequestration	(92,569)	21	4
5	Miscellaneous Income	(117)	21	5
6	Patient Personal Items	(1,022)	10	6
7	Meals	(11,558)	21	7
8	Bank Charges	(7,813)	21	8
9	Charity Discount	(13,982)	20	9
10	Goodwill Amortization	(369,000)	36	10
11	Building Co. - Accounting Fees	(12,000)	19	11
12	Building Co. - Amortization	(5,157)	36	12
13	Building Co. - License	(250)	20	13
14	Building Co. - State Income Tax	(3,761)	21	14
15	PAC Dues	(5,952)	20	15
16	Annual Report	(250)	20	16
17	Non-Allowable Legal	(14,922)	19	17
18	Professional Fees Refund	(296)	19	18
19	Non-Allowable Expense	(792,463)	43	19
20	Marketing Salary	(53,533)	43	20
21	Marketing Expenses	(2,030)	43	21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31

32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,404,610)		49

Elmbrook Nursing

ID# 0051177

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32

82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elmbrook Nursing # 0051177 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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													1
2	Food Purchase	(405)		(2)		10							(397)	2
3	Housekeeping			833									833	3
4	Laundry													4
5	Heat and Other Utilities	(6,163)		1,659									(4,504)	5
6	Maintenance	4,998		1,934		65		(21,850)					(14,853)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(1,570)		4,424		75		(21,850)					(18,921)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(23,956)				(53,227)							(77,183)	10
10a	Therapy													10a
11	Activities			340									340	11
12	Social Services					3,913							3,913	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					155							155	15
16	**TOTAL Health Care and Program**	(23,956)		340		(49,159)							(72,775)	16
	C. General Administration													
17	Administrative					6,521							6,521	17
18	Directors Fees													18
19	Professional Services	(27,218)	12,000	(258,416)	93	451		(3,850)					(276,940)	19
20	Fees, Subscriptions & Promotions	(188,637)	250	458		17							(187,912)	20
21	Clerical & General Office Expenses	(421,419)	3,761	123,668		1,705							(292,285)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			473		14							487	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice		13,228	793									14,021	26
27	Other (specify):*			32,808		492							33,300	27
28	**TOTAL General Administration**	(637,274)	29,239	(100,216)	93	9,200		(3,850)					(702,808)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(662,799)	29,239	(95,452)	93	(39,884)		(25,700)					(794,503)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Elmbrook Nursing # 0051177 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	83,629	190,941	2,111	3,024								279,705	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(10,742)	347,327	12	1,851								338,448	32
33	Real Estate Taxes		68,562	2,666									71,228	33
34	Rent-Facility & Grounds		(938,892)	9,546	(9,546)								(938,892)	34
35	Rent-Equipment & Vehicles					29							29	35
36	Other (specify):*	(374,157)	71,227										(302,930)	36
37	**TOTAL Ownership**	(301,270)	(260,835)	14,335	(4,671)	29							(552,412)	37
	Ancillary Expense													
	E. Special Cost Centers													
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):*	(848,026)											(848,026)	43
44	**TOTAL Special Cost Centers**	(848,026)											(848,026)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,812,095)	(231,596)	(81,117)	(4,578)	(39,855)		(25,700)					(2,194,941)	45

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. [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 Income	$ 938,892	Elmbrook Properties	100.00%	$	$ (938,892)	1
2	V	19	Accounting Fees		Elmbrook Properties	100.00%	12,000	12,000	2
3	V	30	Depreciation		Elmbrook Properties	100.00%	190,941	190,941	3
4	V	36	Amortization		Elmbrook Properties	100.00%	5,157	5,157	4
5	V	26	Insurance		Elmbrook Properties	100.00%	13,228	13,228	5
6	V	32	Interest	223	Elmbrook Properties	100.00%	347,550	347,327	6
7	V	20	License		Elmbrook Properties	100.00%	250	250	7
8	V	36	Mortgage Insurance		Elmbrook Properties	100.00%	66,070	66,070	8
9	V	33	Real Estate Taxes		Elmbrook Properties	100.00%	68,562	68,562	9
10	V	21	State Income Tax		Elmbrook Properties	100.00%	3,761	3,761	10
11	V								11
12	V								12
13	V								13
14	Total			$ 939,115			$ 707,519	$ * (231,596)	14

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

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	2	FOOD	$	Legacy Healthcare Financial Services	100.00%	$ (2)	$ (2)	15
16	V	3	HOUSEKEEPING WAGES		Legacy Healthcare Financial Services	100.00%	744	744	16
17	V	3	HOUSEKEEPING SUPPLIES		Legacy Healthcare Financial Services	100.00%	89	89	17
18	V	5	UTILITIES		Legacy Healthcare Financial Services	100.00%	1,659	1,659	18
19	V	6	GROUNDS & MAINTENANCE		Legacy Healthcare Financial Services	100.00%	1,934	1,934	19
20	V	11	ACTIVITIES PROGRAM		Legacy Healthcare Financial Services	100.00%	340	340	20
21	V	19	PROFESSIONAL FEES		Legacy Healthcare Financial Services	100.00%	5,584	5,584	21
22	V	20	FEES, SUBSCRIPTIONS		Legacy Healthcare Financial Services	100.00%	458	458	22
23	V	21	CLERICAL & GENERAL WAGES		Legacy Healthcare Financial Services	100.00%	116,008	116,008	23
24	V	21	CLERICAL & GENERAL OTHER COSTS		Legacy Healthcare Financial Services	100.00%	7,660	7,660	24
25	V	24	SEMINARS		Legacy Healthcare Financial Services	100.00%	473	473	25
26	V	26	INSURANCE		Legacy Healthcare Financial Services	100.00%	793	793	26
27	V	27	EMP. BEN.-GEN. ADMIN.		Legacy Healthcare Financial Services	100.00%	23,706	23,706	27
28	V	30	DEPRECIATION		Legacy Healthcare Financial Services	100.00%	2,111	2,111	28
29	V	32	INTEREST		Legacy Healthcare Financial Services	100.00%	12	12	29
30	V	33	REAL ESTATE TAXES		Legacy Healthcare Financial Services	100.00%	2,666	2,666	30
31	V	34	RENT		Legacy Healthcare Financial Services	100.00%	9,546	9,546	31
32	V								32
33	V	19	BOOKKEEPING FEES	264,000	Legacy Healthcare Financial Services	100.00%		(264,000)	33
34	V	17	MANAGEMENT FEES	24,098	Legacy Healthcare Financial Services	100.00%		(24,098)	34
35	V	17	MANAGEMENT FEES- C. RAJCHENBACH		Legacy Healthcare Financial Services	100.00%	12,049	12,049	35
36	V	17	MANAGEMENT FEES- M. SHABAT		Legacy Healthcare Financial Services	100.00%	12,049	12,049	36
37	V	27	HEALTH INS/BENEF.- C. RAJCHENBACH		Legacy Healthcare Financial Services	100.00%	4,551	4,551	37
38	V	27	HEALTH INS/BENEF.- M. SHABAT		Legacy Healthcare Financial Services	100.00%	4,551	4,551	38
39	Total			$ 288,098			$ 206,981	$ * (81,117)	39

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

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		Legacy Real Properties	100.00%	93	$ 93	15
16	V	30	DEPRECIATION		Legacy Real Properties	100.00%	3,024	3,024	16
17	V	32	INTEREST EXPENSE		Legacy Real Properties	100.00%	1,851	1,851	17
18	V								18
19	V								19
20	V	34	RENT	9,546	Legacy Real Properties	100.00%		(9,546)	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			$ 9,546			$ 4,968	$ * (4,578)	39

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

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	2	FOOD	$	Progressive Healthcare Consulting	100.00%	$ 10	$ 10	15
16	V	6	BUILDING MAINTENANCE AND R&M		Progressive Healthcare Consulting	100.00%	65	65	16
17	V	10	MEDICAL AND NURSING SUPPLIES		Progressive Healthcare Consulting	100.00%	5	5	17
18	V	10	NURSING SALARIES		Progressive Healthcare Consulting	100.00%	3,831	3,831	18
19	V	12	CLERGY SALARY		Progressive Healthcare Consulting	100.00%	160	160	19
20	V	12	ADMISSIONS SALARY		Progressive Healthcare Consulting	100.00%	3,753	3,753	20
21	V	15	EMP. BEN.-NURSING		Progressive Healthcare Consulting	100.00%	155	155	21
22	V	17	ADMIN SALARY- NON OWNER		Progressive Healthcare Consulting	100.00%	6,521	6,521	22
23	V	19	PROFESSIONAL FEES		Progressive Healthcare Consulting	100.00%	451	451	23
24	V	20	FEES, SUBSCRIPTIONS		Progressive Healthcare Consulting	100.00%	17	17	24
25	V	21	CLERICAL & GENERAL		Progressive Healthcare Consulting	100.00%	1,705	1,705	25
26	V	24	SEMINARS		Progressive Healthcare Consulting	100.00%	14	14	26
27	V	27	AUTO AND TRAVEL		Progressive Healthcare Consulting	100.00%	492	492	27
28	V	35	AUTO RENTAL		Progressive Healthcare Consulting	100.00%	29	29	28
29	V								29
30	V								30
31	V								31
32	V	10	NURSING	57,063	Progressive Healthcare Consulting	100.00%		(57,063)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 57,063			$ 17,208	$ * (39,855)	39

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

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	06	Repairs & Maintenance	$ 5,876	ReMED Services	100.00%	$ 5,876	$	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			$ 5,876			$ 5,876	$ *	39

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

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	06	Repairs & Maintenance	$ 21,850	ML GROUP DESIGN AND DEVELOPMENT		$	$ (21,850)	15
16	V	19	Purchasing Consultant	3,850	ML GROUP DESIGN AND DEVELOPMENT			(3,850)	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			$ 25,700			$	$ * (25,700)	39

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

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 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			$			$	$	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			$			$	$ *	39

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

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 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			$			$	$	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			$			$	$ *	39

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

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 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			$			$	$	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			$			$	$ *	39

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

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 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			$			$	$	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			$			$	$ *	39

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

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	CHICAGO	ELMBROOK PROPERTIES	ELMHURST	BUILDING CO	1
2	MENACHEM SHABAT	34.3750%	BETHANY TERRACE	MORTON GROVE	LEGACY REAL PROPERTIES , L	LINCOLNWOOD	BUILDING CO	2
3	YOSEF AND NAOMI RAJCHENBACH	3.1250%	CHALET LIVING & REHAB	CHICAGO	LEGACY HEALTHCARE & FINA	LINCOLNWOOD	HOME OFFICE / BOOKKEEI	3
4	AVROHOM AND CHAVA RAJCHENBACH	3.1250%	THE GROVE OF EVANSTON,LLC	EVANSTON	PROGRESSIVE HEALTHCARE (	LINCOLNWOOD	NURSING	4
5	PINCHAS AND NAHMA SCHWARTZ	3.1250%	THE VILLA AT EVERGREEN	EVERGREEN PARK	REMED SERVICES LLC	LINCOLNWOOD	DME SALES	5
6	JACK RAJCHENBACH FAMILY TRUST	3.1250%	THE GROVE OF FOX VALLEY	AURORA	ML GROUP DESIGN & DEVELO	LINCOLNWOOD	ASSET MANAGEMENT	6
7	RONALD SHABAT	15.6250%	THE GROVE OF LAGRANGE PARK LLC	LAGRANGE PARK	AURORA SUPPORTIVE LIVING	AURORA	SUPPORTIVE LIVING	7
8	SHLOMO ZALMAN AND CHAVA BUSEL	3.1250%	THE GROVE AT THE LAKE	ZION	TERRACE GARDENS	MORTON GROVE	ASSISTED LIVING	8
9			LAKEFRONT NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO				9
10			THE GROVE AT LINCOLN PARK LIVING AND REHAB CENTER	CHICAGO				10
11			AVANTARA LONG GROVE	LONG GROVE				11
12			THE GROVE NORTH LIVING AND REHAB CENTER,LLC	SKOKIE				12
13			THE GROVE OF NORTHBROOK	NORTHBROOK				13
14			WARREN BARR NORTH SHORE	HIGHLAND PARK				14
15			AVANTARA PARK RIDGE	PARK RIDGE				15
16			PETERSON PARK ASSOCIATES LIMITED PARTNERSHIP	CHICAGO				16
17			WARREN BARR SOUTH LOOP	CHICAGO				17
18			WARREN BARR	CHICAGO				18
19			GROVE AT THE LAKE LIVING AND REHABILITATION	ZION				19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Chaim Rajchenbach	Owner	Administrative	34.38%	See Attached	3.01	6.02%	Mgmt Fees	$ 12,049	17-03	1
2	Menachem Shabat	Owner	Administrative	34.38%	See Attached	3.01	6.02%	Mgmt Fees	12,049	17-03	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	$ 24,098		13

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

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

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 [X]

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	TOTALS					$	$		$	25

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	1 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	2	FOOD	AVAIL. BED DAYS	1,090,513	21	$ (38)	$	65,700	$ (2)	1
2	3	HOUSEKEEPING WAGES	AVAIL. BED DAYS	1,090,513	21	12,349	12,349	65,700	744	2
3	3	HOUSEKEEPING SUPPLIES	AVAIL. BED DAYS	1,090,513	21	1,477		65,700	89	3
4	5	UTILITIES	AVAIL. BED DAYS	1,090,513	21	27,544		65,700	1,659	4
5	6	GROUNDS & MAINTENANCE	AVAIL. BED DAYS	1,090,513	21	32,093		65,700	1,934	5
6	11	ACTIVITIES PROGRAM	AVAIL. BED DAYS	1,090,513	21	5,642		65,700	340	6
7	19	PROFESSIONAL FEES	AVAIL. BED DAYS	1,090,513	21	92,690		65,700	5,584	7
8	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	1,090,513	21	7,596		65,700	458	8
9	21	CLERICAL & GENERAL WA(	AVAIL. BED DAYS	1,090,513	21	1,925,545	1,925,545	65,700	116,008	9
10	21	CLERICAL & GENERAL OTH	AVAIL. BED DAYS	1,090,513	21	127,135		65,700	7,660	10
11	24	SEMINARS	AVAIL. BED DAYS	1,090,513	21	7,856		65,700	473	11
12	26	INSURANCE	AVAIL. BED DAYS	1,090,513	21	13,167		65,700	793	12
13	27	EMP. BEN.-GEN. ADMIN.	AVAIL. BED DAYS	1,090,513	21	393,489		65,700	23,706	13
14	30	DEPRECIATION	AVAIL. BED DAYS	1,090,513	21	35,040		65,700	2,111	14
15	32	INTEREST	AVAIL. BED DAYS	1,090,513	21	199		65,700	12	15
16	33	REAL ESTATE TAXES	AVAIL. BED DAYS	1,090,513	21	44,250		65,700	2,666	16
17	34	RENT	AVAIL. BED DAYS	1,090,513	21	158,445		65,700	9,546	17
18										18
19										19
20										20
21	17	MANAGEMENT FEES- C. RA.	AVG HOURS WKD	50	21	200,000		3.01	12,049	21
22	17	MANAGEMENT FEES- M. SH.	AVG HOURS WKD	50	21	200,000		3.01	12,049	22
23	27	HEALTH INS/BENEF.- C. RAJ	AVG HOURS WKD	50	21	75,547		3.01	4,551	23
24	27	HEALTH INS/BENEF.- M. SHA	AVG HOURS WKD	50	21	75,547		3.01	4,551	24
25	TOTALS					$ 3,435,573	$ 1,937,894		$ 206,981	25

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	1 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	AVAIL. BED DAYS	1,090,513	21	1,550		65,700	93	1
2	30	DEPRECIATION	AVAIL. BED DAYS	1,090,513	21	50,196		65,700	3,024	2
3	32	INTEREST EXPENSE	AVAIL. BED DAYS	1,090,513	21	30,719		65,700	1,851	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					$ 82,465	$		$ 4,968	25

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: 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

	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	2	FOOD	AVAIL. BED DAYS	951,147	18	$ 149	$	65,700	$ 10	1
2	6	BUILDING MAINTENANCE A	AVAIL. BED DAYS	951,147	18	943		65,700	65	2
3	10	MEDICAL AND NURSING SU	AVAIL. BED DAYS	951,147	18	68		65,700	5	3
4	10	NURSING SALARIES	AVAIL. BED DAYS	951,147	18	55,460	55,460	65,700	3,831	4
5	12	CLERGY SALARY	AVAIL. BED DAYS	951,147	18	2,320	2,320	65,700	160	5
6	12	ADMISSIONS SALARY	AVAIL. BED DAYS	951,147	18	54,336	54,336	65,700	3,753	6
7	15	EMP. BEN.-NURSING	AVAIL. BED DAYS	951,147	18	2,247		65,700	155	7
8	17	ADMIN SALARY- NON OWNE	AVAIL. BED DAYS	951,147	18	94,409	94,409	65,700	6,521	8
9	19	PROFESSIONAL FEES	AVAIL. BED DAYS	951,147	18	6,532		65,700	451	9
10	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	951,147	18	250		65,700	17	10
11	21	CLERICAL & GENERAL	AVAIL. BED DAYS	951,147	18	24,680		65,700	1,705	11
12	24	SEMINARS	AVAIL. BED DAYS	951,147	18	199		65,700	14	12
13	27	EMPLOYEE BENEFITS	AVAIL. BED DAYS	951,147	18	7,129		65,700	492	13
14	35	AUTO RENTAL	AVAIL. BED DAYS	951,147	18	413		65,700	29	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 249,135	$ 206,525		$ 17,208	25

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: ReMed Services, LLC
Street Address: 7040 N. Ridgeway Avenue
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: ((855) 501-5500
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	6	REPAIRS AND MAINTENANCE				$	$		$ 5,876	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					$	$		$ 5,876	25

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: ML Group Design and Development
Street Address: 7040 N. Ridgeway Avenue
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: (773) 415-3071
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	6	REPAIRS AND MAINTENANCE				$	$		$	1
2	19	PURCHASING CONSULTANT								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

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	TOTALS					$	$		$	25

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	TOTALS					$	$		$	25

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	TOTALS					$	$		$	25

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	TOTALS					$	$		$	25

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Greystone		X	Mortgage Note			$	$ 13,045,532			$ 347,550	1
2												2
3												3
4												4
5												5
	Working Capital											
6	The Private Bank		X	Line of Credit							13,203	6
7	Allocated from Legacy Financ. Serv.		X								12	7
8	See Supplemental Schedule										1,851	8
9	TOTAL Facility Related						$	$ 13,045,532			$ 362,616	9
	B. Non-Facility Related*											
10	Interest Income		X								(10,742)	10
11	Interest Income - Bldg Co.		X								(223)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (10,965)	14
15	TOTALS (line 9+line14)						$	$ 13,045,532			$ 351,651	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 66,070 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 Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** 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							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocated from Legacy Real Propertie		X				$	$			$ 1,851	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										1,851	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* 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: 01/01/14 Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 4,993	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.)		$ 69,491	2
3. Under or (over) accrual (line 2 minus line 1).		$ 64,498	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 70,166	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.		$ 134,664	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2009		8
2010	57,682	9
2011	63,434	10
2012	65,169	11
2013	66,825	12

2014 Accrual: $66,825 x 1.05 = $70,166 (Rounded)

*Beginning Accrual Adjusted

Allocated from Legacy Healthcare Financial Services- $2,666

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 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 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-26-207-022	Long Term Care Facility	$ 5,257.74	$ 5,257.74
2.	03-26-207-025	Long Term Care Facility	$ 61,566.76	$ 61,566.76
3.	See Attached	See Attached	$ 38,392.03	$ 2,313.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 105,216.53	$ 69,137.50

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 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 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$

3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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: 01/01/14 Ending: 12/31/14

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 [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).

None

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	Facility	67,000	2010	$ 606,331	1
2	Allocated from Legacy Real Properties			4,929	2
3	TOTALS	67,000		$ 611,260	3

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	180		2010	1977	$ 7,403,102	$ 132,829	35	$ 211,517	$ 78,688	$ 849,443	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	
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	Related Building Company (Pages 12F & 12G)			57,112			(57,112)		67
68	Related Party Allocations (Pages 12H & 12I)		83,591	2,567		3,478	911	16,049	68
69	Financial Statement Depreciation			487,478			(487,478)		69
70	TOTAL (lines 4 thru 69)		$ 7,486,693	$ 679,986		$ 214,995	$ (464,991)	$ 865,492	70

**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: 01/01/14 Ending: 12/31/14

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 12A, Carried Forward		$ 7,486,693	$ 679,986		$ 214,995	$ (464,991)	$ 865,492	1
2	Sprinklers - Systems Piping #2354	2011	6,826		20	171	171	683	2
3	Remodeling- Demolish Walls, New Walls, Paint	2011	4,650		20	116	116	465	3
4	3Rd Floor Bathrooms - Plumbing, Paint, Tile	2011	7,680		20	384	384	1,536	4
5	Replace Compressor On Air Conditioning Unit	2011	20,565		20	1,028	1,028	4,113	5
6	Replace Lining For Cooling Tower	2011	3,960		20	198	198	792	6
7	New Phone System	2011	6,440		20	322	322	1,288	7
8	Resident Rooms - Built In Furniture/Drywall/Wallpaper/Paint/Bas	2011	74,419		20	3,721	3,721	14,884	8
9	Sliding Door/Entrance	2011	5,123		20	256	256	1,025	9
10	Interior Signage	2011	9,825		20	491	491	1,965	10
11	Exterior Signage	2011	13,270		20	664	664	2,654	11
12	Electrical - Phone Jack Intallation/Low Voltage/Duplex Outlets	2011	56,290		20	2,815	2,815	11,258	12
13	Land Improvements - Paint Fence, Paving	2011	52,484		20	2,624	2,624	10,497	13
14	Project A - Lobby - Tiling/Crown Molding/Window/Wall Coverin	2011	31,193		20	1,560	1,560	6,239	14
15	Project B - 1St Floor Cooridor - Handrails/Flooring/Tiling/Wallpa	2011	103,292		20	5,165	5,165	20,658	15
16	Project C - 1St Floor Resident Rooms - New Fixtures/Built In Hea	2011	29,734		20	1,487	1,487	5,947	16
17	Project D - 2Nd Floor Resident Rooms - Light Fixtures/Headboard	2011	57,548		20	2,877	2,877	11,510	17
18	Project E - 2Nd Floor Therapy Rooms - Dividing Wall/Wallpaper/	2011	40,936		20	2,047	2,047	8,187	18
19	Project F - 2Nd Floor Therapy Bathrooms - Flooring/Fixtures	2011	5,709		20	285	285	1,142	19
20	Project G - 3Rd Floor Resident Rooms - Light Fixtures/Paint/Win	2011	25,239		20	1,262	1,262	5,048	20
21	Project H - Front Offices - Flooring/Paint/Window	2011	17,943		20	897	897	3,589	21
22	Project I - Elevator - Cab Systems	2011	15,108		20	755	755	3,022	22
23	Project J - 1St Floor Nurses Station - Charting Unit/Railing/Tiling	2011	13,307		20	665	665	2,661	23
24	Project K - Resident Bathrooms - Flooring/Painting	2011	8,315		20	416	416	1,663	24
25	Project L - 2Nd Floor Nurses Station - Nurses Station/Charting Ur	2011	11,652		20	583	583	2,330	25
26	Project M - 2Nd Floor Dining Room - Flooring/Wallcovering/Win	2011	24,849		20	1,242	1,242	4,970	26
27	Project N - 3Rd Floor Nurses Station - Nurses Station/Charting Ur	2011	11,652		20	583	583	2,330	27
28	Project O - 3Rd Floor Corridor - Flooring/Cove Base	2011	33,005		20	1,650	1,650	6,601	28
29	Project P - 3Rd Floor Dining Room - Flooring/Molding/Wallpaper	2011	36,984		20	1,849	1,849	7,397	29
30	Project Q - 2Nd Floor Corridor - Tiling/Flooring/Crown Molding/	2011	65,334		20	3,267	3,267	13,067	30
31	Wallpaper, Drywall, Paint	2011	2,800		20	140	140	560	31
32	Air Conditioning Unit	2011	4,250		20	213	213	850	32
33	Corner Guards, Lighting, Signage, Wallpaper	2011	4,176		20	209	209	835	33
34	TOTAL (lines 1 thru 33)		$ 8,291,251	$ 679,986		$ 254,936	$ (425,050)	$ 1,025,256	34

**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: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 8,291,251	$ 679,986		$ 254,936	$ (425,050)	$ 1,025,256	1
2	Wallpaper, Paint, Locks, Power Outlets	2011	5,325		20	266	266	1,065	2
3	Wallpaper, Paint, Baseboards	2011	5,100		20	255	255	1,020	3
4	Exterior Caulking	2011	5,500		20	275	275	1,100	4
5	Front Entrance - Fix Damaged Floor, Paint	2011	2,950		20	148	148	590	5
6	Air Handler Repair	2011	2,609		20	130	130	522	6
7	Demolish And Renovate Basement Room/Drywall/Paint/Electric/F	2011	5,750		20	288	288	1,150	7
8	Demolition: Remove All Damaged Drywall. Rough Carpentry: Re	2012	36,875		20	1,844	1,844	4,609	8
9	Wallcovering Supply 120 Yrds - Retreat Glacier, Wallcovering Su	2012	4,210		20	211	211	509	9
10	Water Based Adhesive And A 60Mil Sinfle Ply Ib Decking Shield.	2012	14,560		20	728	728	1,577	10
11	26 Door Locks, Renovate Basement Staff Bathroom And Build Ne	2012	8,625		20	431	431	934	11
12	Staff Office Repair: Build New Partion Wall, Remove Wall By Sto	2012	11,850		20	593	593	1,284	12
13	Add 4"-6" Of Compacted Rock Base, Install New Patio Of Hollan	2012	4,025		20	201	201	419	13
14	Replace 68 Lavatory Faucets, Install All New Water Supply Hoses	2012	10,200		20	510	510	1,190	14
15	Hot Water Boiler Replacement.	2012	12,900		20	645	645	1,881	15
16	Trane Twin Screw Chiller Unit.	2012	104,726		20	5,236	5,236	14,836	16
17	Fan Belt, Electrical Damper Motor, Commercial Service Call, Hel	2012	3,926		20	196	196	474	17
18	6 Gaskets	2012	4,440		20	222	222	555	18
19	Hose, Valve, Belt, Soil, Ect.....	2012	2,796		20	140	140	326	19
20	Elevator Ceiling, New Lighting System.	2012	3,716		20	186	186	542	20
21	New Tiles - Vinyl	2012	7,050		20	353	353	911	21
22	Railing Bars For The Existing Staircase, Additional Bars	2012	6,950		20	348	348	869	22
23	Corridor Repair, Cubicle Curtains, Signage & Installation	2012	6,153		20	308	308	769	23
24	Wallpaper	2013	5,154		20	1,031	1,031	1,976	24
25	Wash Pump & Gasket Installation	2013	3,244		20	649	649	1,190	25
26	Furnish And Install Wanderguard System	2013	6,175		20	1,235	1,235	1,338	26
27	Walls, Ceiling Tiles, Light Fixtures, Etc.	2013	5,805		20	290	290	581	27
28	Relocated 2" Main And Installed Concealed Pendant Heads, Lowe	2013	5,952		20	298	298	546	28
29	Lower Level Corridor - Flooring, Plank-Washed Teak Tick Surfac	2013	12,214		20	611	611	1,120	29
30	Dining Room And Hallway - Drywall, Wallpaper, Door, Railing	2013	48,957		20	2,448	2,448	4,080	30
31	Fire Damper	2013	3,213		20	161	161	254	31
32	Landscape Irrigation System	2013	10,500		20	700	700	1,108	32
33	Fire Dampers, X6	2013	4,194		20	210	210	315	33
34	TOTAL (lines 1 thru 33)		$ 8,666,896	$ 679,986		$ 276,079	$ (403,907)	$ 1,074,895	34

**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: 01/01/14 Ending: 12/31/14

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		$ 8,666,896	$ 679,986		$ 276,079	$ (403,907)	$ 1,074,895	1
2	Vinyl Hand Railings, Corner Guard	2013	5,805		20	290	290	435	2
3	Lower Level Corridor - Flooring, Contour Plank, Contour Stone,	2013	9,344		20	467	467	545	3
4	Landscaping - Stripped & Repair Lawn, Installed Soil, Plant Mate	2013	35,370		20	1,769	1,769	2,800	4
5	Basement Hallway/Launch Room - Drop Ceiling, Soffits,Walls,Tili	2014	26,850		20	1,119	1,119	1,119	5
6	Elevator Repairs	2014	6,374		20	740	740	740	6
7	Ldry Rm, Bsmt Hall, Dr. Launch Room-Walls/Doors/Drop Ceiling	2014	15,000		20	750	750	750	7
8	Lower Level-Reworked Existing Sprinkler System To Meet New C	2014	5,300		20	177	177	177	8
9	Disconnected And Removed Existing #1 Circulating Pump, 1 Thru	2014	6,489		20	189	189	189	9
10	Green Room - Patch Walls, Paint, Ceiling Light, Cove Base	2014	5,000		20	250	250	250	10
11	Repaired Air Conditioner	2014	14,889		20	744	744	744	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)		$ 8,797,316	$ 679,986		$ 282,574	$ (397,412)	$ 1,082,645	34

**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: 01/01/14 Ending: 12/31/14

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 12D, Carried Forward		$ 8,797,316	$ 679,986		$ 282,574	$ (397,412)	$ 1,082,645	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,797,316	$ 679,986		$ 282,574	$ (397,412)	$ 1,082,645	34

**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: 01/01/14 Ending: 12/31/14

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 12E, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9									9
10									10
11									11
12									12
13	Additional Depreciation			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	TOTAL (lines 1 thru 33)		$	$ 57,112		$	$ (57,112)	$	34

**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: 01/01/14 Ending: 12/31/14

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 12F, Carried Forward		$	$ 57,112		$	$ (57,112)	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$ 57,112		$	$ (57,112)	$	34

**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: 01/01/14 Ending: 12/31/14

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 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Legacy Real Properties	2009	38,188	1,273	20	1,273		7,001	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from Legacy Healthcare Financial Services	2012	1,718	119	20	86	(33)	258	9
10	Allocated from Legacy Healthcare Financial Services	2013	5,495	381	20	275	(106)	549	10
11	Allocated from Legacy Healthcare Financial Services	2014	536	37	20	27	(10)	27	11
12									12
13	Allocated from Legacy Real Properties	2009	21,687	542	20	1,084	542	5,151	13
14	Allocated from Legacy Real Properties	2010	6,594	215	20	264	49	1,188	14
15	Allocated from Legacy Real Properties	2011	9,373		20	469	469	1,875	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)		$ 83,591	$ 2,567		$ 3,478	$ 911	$ 16,049	34

**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: 01/01/14 Ending: 12/31/14

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 12H, Carried Forward		$ 83,591	$ 2,567		$ 3,478	$ 911	$ 16,049	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 83,591	$ 2,567		$ 3,478	$ 911	$ 16,049	34

**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: 01/01/14 Ending: 12/31/14

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	$ 2,728,836	$ 2,889	$ 463,103	$ 460,214	10	$ 1,946,994	71
72	Current Year Purchases	212,171	678	21,506	20,828	10	21,506	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,941,007	$ 3,567	$ 484,608	$ 481,041		$ 1,968,499	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)	$ 12,349,583	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 683,553	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 767,182	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 83,629	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,051,144	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 Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 13,744 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	Allocated from Progressive Healthcare Consulting		$	$ 29	17
18					18
19					19
20					20
21	TOTAL		$	$ 29	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 Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

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 Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 325,657	$		$ 325,657	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			149,149			149,149	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			612,706			612,706	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				220,704		220,704	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					55,692	95,773		151,465	13
14	TOTAL			$		$ 1,143,204	$ 316,477		$ 1,459,681	14

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

Facility Name & ID Number Elmbrook Nursing **#** 0051177 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (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	$	$ 66,320	1
2	Cash-Patient Deposits	10,499	10,499	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,062,321	2,062,321	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	127,544	190,307	6
7	Other Prepaid Expenses	126,838	233,608	7
8	Accounts Receivable (owners or related parties)	2,764,904	2,764,904	8
9	Other(specify):	168,566	610,747	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,260,672	$ 5,938,706	10
	B. Long-Term Assets			
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	550,052	1,220,183	15
16	Equipment, at Historical Cost	2,389,840	2,404,840	16
17	Accumulated Depreciation (book methods)	(1,793,968)	(2,566,869)	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):	2,952,000	2,952,000	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,097,924	$ 10,499,989	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,358,596	$ 16,438,695	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,331,395	$ 1,331,394	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	68	68	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	627,398	627,398	30
31	Accrued Taxes Payable (excluding real estate taxes)	75,873	75,873	31
32	Accrued Real Estate Taxes(Sch.IX-B)		70,166	32
33	Accrued Interest Payable		28,591	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	764,883	74,039	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,799,617	$ 2,207,529	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		13,045,532	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)**	$	$ 13,045,532	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,799,617	$ 15,253,061	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 6,558,979	$ 1,185,634	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,358,596	$ 16,438,695	48

***(See instructions.)**

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 6,894,401	1
2	Restatements (describe):		2
3	**Amortization of goodwill**	(369,000)	3
4	**Decrease in allowance for doubtful/accrued sequestration**	133,731	4
5	**R&M**	(204)	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 6,658,928	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	275,051	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	(375,000)	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)**	$ (99,949)	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)**	$ 6,558,979	24 *

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

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,199,248	1
2	Discounts and Allowances for all Levels	(3,205,310)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,993,938	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,630,631	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,630,631	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	231,196	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	46,840	19
20	Radiology and X-Ray	13,085	20
21	Other Medical Services	10,748	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 301,869	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	10,742	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 10,742	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	12,992	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 12,992	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,950,172	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,724,211	31
32	Health Care	4,487,794	32
33	General Administration	2,871,279	33
	B. Capital Expense		
34	Ownership	1,885,753	34
	C. Ancillary Expense		
35	Special Cost Centers	2,307,707	35
36	Provider Participation Fee	398,377	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,675,121	40
41	**Income before Income Taxes (line 30 minus line 40)****	275,051	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 275,051	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,502,243	44
45	Private Pay - Net Inpatient Revenue	1,351,222	45
46	Medicare - Net Inpatient Revenue	964,933	46
47	Other-(specify) Veteran	147,712	47
48	Other-(specify) Insurance	27,828	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,993,938	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.**

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	1,993	2,248	$ 115,166	$ 51.23	1
2	Assistant Director of Nursing	1,937	2,430	94,355	38.83	2
3	Registered Nurses	26,324	28,909	1,062,516	36.75	3
4	Licensed Practical Nurses	26,897	29,425	740,355	25.16	4
5	CNAs & Orderlies	96,664	104,649	1,343,722	12.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,023	11,999	243,477	20.29	8
9	Activity Director	1,969	2,198	42,063	19.14	9
10	Activity Assistants	10,270	11,180	182,293	16.31	10
11	Social Service Workers	6,260	6,792	123,068	18.12	11
12	Dietician					12
13	Food Service Supervisor	1,969	2,046	53,033	25.92	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,559	28,535	319,134	11.18	15
16	Dishwashers					16
17	Maintenance Workers	3,854	4,085	82,781	20.26	17
18	Housekeepers	18,016	20,450	273,823	13.39	18
19	Laundry	5,492	6,657	92,375	13.88	19
20	Administrator	1,301	1,523	81,149	53.28	20
21	Assistant Administrator	903	977	39,941	40.88	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	27,511	29,903	413,189	13.82	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,079	2,289	74,198	32.42	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,438	1,566	37,803	24.14	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,273	2,376	54,341	22.87	33
34	TOTAL (lines 1 - 33)	273,732	300,237	$ 5,468,782 *	$ 18.21	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	397	$ 18,476	01-03	35
36	Medical Director	Monthly	47,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	35,192	10-03	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	391	3,906	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	94	5,528	12-03	45
46	Other(specify)				46
47	Clergy	Monthly	3,688	12-03	47
48	MDS Consultant	Monthly	71,175	10-03	48
49	TOTAL (lines 35 - 48)	882	$ 185,465		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mark Murphey	Administrator	0.00%	$ 33,478
Theodore O'Brien	Administrator	0.00%	47,672
Eliyahu, Barnett (3/17/14-12/31/14)	Assistant Admin	0.00%	39,941
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 121,090

B. Administrative - Other

Description	Amount
Chaim Rajchenbach - Management Fees	$ 12,049
Menachem Shabat - Management Fees	12,049
TOTAL (agree to Schedule V, line 17, col. 3)	$ 24,098
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legacy Healthcare	Bookkeeping Fees	$ 264,000
Frost, Ruttenberg, Rothblatt	Accounting	33,616
Abbie Graham	Accounting	931
David Etzman	Accounting	1,398
Achieve Accreditation LLC	Joint Commission Cons.	9,341
The Joint Commission	Joint Commission Cons.	2,750
Personnel Planners	Unemployment Consultant	4,529
Illinois Rytes Corp	Compliance	12,000
Prospect Resources	Energy Procurement	800
IIT/Sourcetech	Data Processing	1,870
Ability Network	Data Processing	1,244
See Supplemental Schedule		150,268
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 482,748

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 152,499
Unemployment Compensation Insurance	113,802
FICA Taxes	413,351
Employee Health Insurance	151,877
Employee Meals	46,516
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension	82,790
Employee Physical Exam	3,647
Other Employee Benefits	25,132
TOTAL (agree to Schedule V, line 22, col.8)	$ 989,614

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	277
Health Care Worker Background Check	2,342
(Indicate # of checks performed 120)	
Patient Background Checks	
Dues and Subscriptions	19,597
License and Permits	298
Allocated from Legacy Financial	458
Allocated from Progressive HC	17
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,989

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,906
Allocated for Legacy Financial	473
Allocated from Progressive HC	14
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,393

**See instructions.

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

Facility Name & ID Number Elmbrook Nursing # 0051177 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: $18,036**

(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. $ **63,819** 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. $ **398,377**
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. $ **46,516** 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.