

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 0040410

Facility Name: Elmwood Care

Address: 7733 W. Grand Ave . Elmwood Park 60635
Number City Zip Code

County: Cook

Telephone Number: (708) 452-9200 Fax # (708) 452-9294

HFS ID Number:

Date of Initial License for Current Owners: 04/01/93

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☒ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ 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 01/01/11 to 12/31/11 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) Cary Drazner, 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>245</u>	Skilled (SNF)	<u>245</u>	<u>89,425</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>245</u>	TOTALS	<u>245</u>	<u>89,425</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>57,865</u>	<u>3,556</u>	<u>9,564</u>	<u>70,985</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>57,865</u>	<u>3,556</u>	<u>9,564</u>	<u>70,985</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.38%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

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

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

I. On what date did you start providing long term care at this location? Date started 04/01/93

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 04/01/93 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 245 and days of care provided 7,971

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	372,705	59,049	65,508	497,262		497,262	(21,653)	475,609			1
2	Food Purchase		383,276		383,276	(44,983)	338,293	(191)	338,102			2
3	Housekeeping	275,363	81,498		356,861		356,861	(2,748)	354,113			3
4	Laundry	106,276	48,464		154,740		154,740	(13)	154,727			4
5	Heat and Other Utilities			241,592	241,592		241,592	(6,870)	234,722			5
6	Maintenance	92,329	50,214	350,242	492,785		492,785	(22,782)	470,003			6
7	Other (specify):*							5,728	5,728			7
8	TOTAL General Services	846,673	622,501	657,342	2,126,516	(44,983)	2,081,533	(48,529)	2,033,004			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	4,333,882	855,126	69,858	5,258,866		5,258,866	(137,926)	5,120,940			10
10a	Therapy	255,298		66,215	321,513		321,513	(17,936)	303,577			10a
11	Activities	118,773	11,645	2,448	132,866		132,866		132,866			11
12	Social Services	250,404		3,599	254,003		254,003		254,003			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							6,168	6,168			15
16	TOTAL Health Care and Programs	4,958,357	866,771	146,920	5,972,048		5,972,048	(149,695)	5,822,353			16
	C. General Administration											
17	Administrative	311,601		610,211	921,812		921,812	(499,614)	422,198			17
18	Directors Fees											18
19	Professional Services			248,971	248,971	(18,496)	230,475	(129,185)	101,290			19
20	Dues, Fees, Subscriptions & Promotions			75,624	75,624		75,624	(21,956)	53,668			20
21	Clerical & General Office Expenses	130,445	53,449	564,974	748,868		748,868	(366,595)	382,273			21
22	Employee Benefits & Payroll Taxes			1,091,163	1,091,163	44,983	1,136,146		1,136,146			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,567	5,567		5,567	(1,366)	4,201			24
25	Other Admin. Staff Transportation			5,328	5,328		5,328	10,150	15,478			25
26	Insurance-Prop.Liab.Malpractice			168,335	168,335		168,335	1,661	169,996			26
27	Other (specify):*							45,227	45,227			27
28	TOTAL General Administration	442,046	53,449	2,770,173	3,265,668	26,487	3,292,155	(961,677)	2,330,477			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,247,076	1,542,721	3,574,435	11,364,232	(18,496)	11,345,736	(1,159,901)	10,185,835			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			122,008	122,008		122,008	602,731	724,739			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			145,147	145,147		145,147	951,244	1,096,391			32
33	Real Estate Taxes					18,496	18,496	375,590	394,086			33
34	Rent-Facility & Grounds			1,944,000	1,944,000		1,944,000	(1,944,000)				34
35	Rent-Equipment & Vehicles			7,648	7,648		7,648	7,387	15,035			35
36	Other (specify):*											36
37	TOTAL Ownership			2,218,803	2,218,803	18,496	2,237,299	(7,048)	2,230,251			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	936,771	905,136	951,499	2,793,406		2,793,406	(32,069)	2,761,337			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			387,138	387,138		387,138		387,138			42
43	Other (specify):*	44,434			44,434		44,434	(44,434)	(0)			43
44	TOTAL Special Cost Centers	981,205	905,136	1,338,637	3,224,978		3,224,978	(76,503)	3,148,475			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,228,281	2,447,857	7,131,875	16,808,013		16,808,013	(1,243,453)	15,564,560			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Refer- ence	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	(9,615)	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	166,114	30		9
10	Interest and Other Investment Income	(1,409)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(191)	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				18
19	Entertainment				19
20	Contributions	(8,040)	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	(451,320)	21		24
25	Fund Raising, Advertising and Promotional	(9,316)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(180,470)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (495,247)		\$	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)	(748,206)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (748,206)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,243,453)		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

Elmwood Care

	ID#	0040410
Report Period Beginning:		01/01/11
Ending:		12/31/11

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Therapy Expenses - VA	\$ (29,744)	10	1
2	Jury Duty - Misc. Income	(69)	21	2
3	Nursing Edu. Program - Misc. Income	(2,080)	21	3
4	Bank Fees	(5,845)	21	4
5	COPE Dues	(5,833)	20	5
6	Marketing Salaries	(44,434)	43	6
7	Collections	(7,422)	21	7
8	Non-Allowable Legal	(585)	19	8
9	Additional R&M	2,212	06	9
10	Filing Fees - Building Co.	(959)	21	10
11	Amortization - Building Co.	(66,409)	36	11
12	Office Expense - Building Co.	(1,290)	21	12
13	Capitalized R&M	(6,772)	06	13
14	Professional Fees - Building Co.	(3,171)	19	14
15	X-Ray-Exp-Part A	(2,087)	39	15
16	Laboratory-Exp-Part-A	(5,981)	39	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(180,470)		49

Elmwood Care

	ID#	0040410
Report Period Beginning:		01/01/11
Ending:		12/31/11

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
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81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98				49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				(21,653)								(21,653)	1
2	Food Purchase	(191)											(191)	2
3	Housekeeping						(2,748)						(2,748)	3
4	Laundry						(13)						(13)	4
5	Heat and Other Utilities	(9,615)			2,745								(6,870)	5
6	Maintenance	(4,560)		(18,127)	(46)		(49)						(22,782)	6
7	Other (specify):*			895	4,833								5,728	7
8	TOTAL General Services	(14,366)		(17,232)	(14,121)		(2,810)						(48,529)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(29,744)		(42,296)	8,058	(24,300)	(49,644)						(137,926)	10
10a	Therapy				(17,936)								(17,936)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			2,836	3,332								6,168	15
16	TOTAL Health Care and Programs	(29,744)		(39,460)	(6,547)	(24,300)	(49,644)						(149,695)	16
	C. General Administration													
17	Administrative			(581,959)	82,345								(499,614)	17
18	Directors Fees													18
19	Professional Services	(3,756)	18,171	(160,674)	17,074								(129,185)	19
20	Fees, Subscriptions & Promotions	(23,189)		1,233									(21,956)	20
21	Clerical & General Office Expenses	(469,985)	2,249	101,065	76								(366,595)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			(1,366)									(1,366)	24
25	Other Admin. Staff Transportation			10,150									10,150	25
26	Insurance-Prop.Liab.Malpractice			1,532	129								1,661	26
27	Other (specify):*			26,634	18,593								45,227	27
28	TOTAL General Administration	(496,929)	20,420	(603,385)	118,217								(961,677)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(541,040)	20,420	(660,077)	97,549	(24,300)	(52,454)						(1,159,901)	29

Summary B

12/31/11

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	166,114	420,178		8,766	7,865	(193)						602,731	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,409)	954,369	(9,275)	7,559								951,244	32
33	Real Estate Taxes		368,694		6,896								375,590	33
34	Rent-Facility & Grounds		(1,944,000)										(1,944,000)	34
35	Rent-Equipment & Vehicles			7,387									7,387	35
36	Other (specify):*	(66,409)	66,409											36
37	TOTAL Ownership	98,296	(134,350)	(1,888)	23,221	7,865	(193)						(7,048)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(8,069)				(24,000)							(32,069)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(44,434)											(44,434)	43
44	TOTAL Special Cost Centers	(52,503)				(24,000)							(76,503)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(495,247)	(113,930)	(661,965)	120,770	(40,435)	(52,646)						(1,243,453)	45

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent-Base	\$ 1,944,000	Elmwood Grand, LLC	100.00%	\$	(1,944,000)	1
2	V	36	Amortization		Elmwood Grand, LLC	100.00%	66,409	66,409	2
3	V	30	Depreciation		Elmwood Grand, LLC	100.00%	420,178	420,178	3
4	V	21	Filing Fees		Elmwood Grand, LLC	100.00%	959	959	4
5	V	32	Interest	2,305	Elmwood Grand, LLC	100.00%	956,674	954,369	5
6	V	21	Office Expense		Elmwood Grand, LLC	100.00%	1,290	1,290	6
7	V	19	Professional Fees		Elmwood Grand, LLC	100.00%	3,171	3,171	7
8	V	33	Real Estate Taxes		Elmwood Grand, LLC	100.00%	368,694	368,694	8
9	V	19	Real Estate Related Prof Fees		Elmwood Grand, LLC	100.00%	15,000	15,000	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,946,305			\$ 1,832,375	\$ * (113,930)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS AND MAINT.	\$ 29,400	S.I.R. MANAGEMENT, INC.	100.00%	\$ 11,273	\$ (18,127)	15
16	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	895	895	16
17	V	10	NURSING	58,800	S.I.R. MANAGEMENT, INC.	100.00%	16,504	(42,296)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	2,836	2,836	18
19	V	19	PROFESSIONAL FEES	174,180	S.I.R. MANAGEMENT, INC.	100.00%	13,506	(160,674)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	1,233	1,233	20
21	V	21	CLERICAL & GENERAL	58,800	S.I.R. MANAGEMENT, INC.	100.00%	55,530	(3,270)	21
22	V	24	EDUCATION & SEMINAR	2,102	S.I.R. MANAGEMENT, INC.	100.00%	736	(1,366)	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	10,150	10,150	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,532	1,532	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	4,869	4,869	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(9,275)	(9,275)	26
27	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	7,387	7,387	27
28	V								28
29	V	17	ADMINISTRATIVE	610,211	S.I.R. MANAGEMENT, INC.	100.00%	28,252	(581,959)	29
30	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	2,029		30
31	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	104,335	104,335	31
32	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	21,765	21,765	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 933,493			\$ 273,557	\$ * (661,965)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	\$ 29,400	S.I.R. MANAGEMENT, INC.	100.00%	\$ 7,747	\$ (21,653)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,347	1,347	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	8,058	8,058	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	1,395	1,395	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	82,345	82,345	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	16,018	16,018	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	18,593	18,593	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	29,400	S.I.R. MANAGEMENT, INC.	100.00%	11,464	(17,936)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,937	1,937	25
26	V								26
27	V	6	MAINTENANCE SALARIES	18,561	S.I.R. MANAGEMENT, INC.	100.00%	17,392	(1,169)	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	3,486	3,486	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	2,745	2,745	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	1,123	1,123	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	60	60	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	76	76	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	129	129	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	8,766	8,766	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	7,559	7,559	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	6,896	6,896	37
38	V	19	PROFESSIONAL FEES (RE TAX)		S.I.R. MANAGEMENT, INC.	100.00%	996	996	38
39	Total			\$ 77,361			\$ 198,131	\$ * 120,770	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V							\$	15
16	V	10	RESPIATORY CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	(24,300)	(24,300)	16
17	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	7,865	7,865	17
18	V								18
19	V								19
20	V								20
21	V	39	EQUIPMENT LEASING	24,000	S.I.R. MANAGEMENT, INC.	100.00%		(24,000)	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			\$ 24,000			\$ (16,435)	\$ * (40,435)	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Xcel Supply, LLC	100.00%	\$	\$	15
16	V	3	Housekeeping	45,328	Xcel Supply, LLC	100.00%	42,580	(2,748)	16
17	V	4	Laundry	211	Xcel Supply, LLC	100.00%	198	(13)	17
18	V	6	Repairs & Maintenance	808	Xcel Supply, LLC	100.00%	759	(49)	18
19	V	10	Nursing	818,892	Xcel Supply, LLC	100.00%	769,248	(49,644)	19
20	V	11	Activities		Xcel Supply, LLC	100.00%			20
21	V	21	Office And Clerical		Xcel Supply, LLC	100.00%			21
22	V	22	Employee Benefits		Xcel Supply, LLC	100.00%			22
23	V	30	Fixed Assets-Depreciation	3,176	Xcel Supply, LLC	100.00%	2,983	(193)	23
24	V	39	Ancillary		Xcel Supply, LLC	100.00%			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			\$ 868,415			\$ 815,769	\$ * (52,646)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 105,822	\$ 105,822	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	105,822	CCS Employee Benefits Group	100.00%		(105,822)	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			\$ 105,822			\$ 105,822	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ADAM VALES TRUST	2.881%	ALBANY CARE INC	EVANSTON	ELMWOOD-GRAND, LLC	LINCOLNWOOD	BUILDING CO.	1
2	BRYAN BARRISH TRUST DTD 09/01/2004	14.249%	BRYN MAWR CARE INC.	CHICAGO	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	2
3	CELESTE GIANNINI TRUST DTD 3/13/00	17.747%	COLUMBUS PARK NURSING & REHABILITATION CENTER, INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	DANIEL ROTHNER TRUST	2.881%	DECATUR MANOR HEALTHCARE,LLC	DECATUR	EXTENDED CARE-OWNER'S CC	LINCOLNWOOD	MANAGEMENT CO.	4
5	DENNIS TOSSI	0.823%	FAIRVIEW NURSING PLAZA, INC.	ROCKFORD	XCEL MEDICAL SUPPLY, LLC	EVANSTON	SUPPLIES	5
6	GALE ROTHNER	9.465%	GREENWOOD CARE, INC.	EVANSTON	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	6
7	HARVEY SCOTT	0.823%	MAPLEWOOD CARE, INC.	ELGIN				7
8	JEFF ORAVEC	0.412%	NEIGHBORS REHABILITATION CENTER,LLC	BYRON				8
9	JOEY ABRAMCHIK	2.058%	REGENCY REHABILITATION CENTER,LLC	NILES				9
10	JULIANA R. BARRISH TRUST DTD 1/26/93	14.249%	ROCK ISLAND NURSING & REHAB CENTER,LLC	ROCK ISLAND				10
11	KATHRYN VALES TRUST	2.881%	WILSON CARE, INC.	CHICAGO				11
12	KIMBERLY RICHMAN TRUST	2.881%	APPLEWOOD REHABILITATION CENTER	MATTESON				12
13	LORI BARRISH	2.058%						13
14	LOUISE BERGTHOLD	4.938%						14
15	MELISSA ROTHNER TRUST	2.881%						15
16	MICHAEL R GIANNINI TRUST DTD 3/13/00	11.574%						16
17	RACHEL ROTHNER TRUST	2.881%						17
18	THOMAS WINTER	1.440%						18
19	WILLIAM ROTHNER TRUST	2.881%						19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Relative	Administrative	N/A	See Attached	0.51	1.10%	Alloc. Salary	\$ 11,551	17-7	1
2	Bryan Barrish	Shareholder	Administrative	14.25	See Attached	3.39	7.53%	Alloc. Salary	16,950	17-7	2
3	Michael Giannini	Shareholder	Administrative	11.57	See Attached	2.97	7.43%	Alloc. Salary	14,153	17-7	3
4	Nenita Guzman	Relative	Dietary	N/A	See Attached	4.24	8.48%	Alloc. Salary	7,747	1-7	4
5	Sarah Barrish	Relative	Administrative	N/A	See Attached	4.24	8.48%	Alloc. Salary	10,148	17-7	5
6	Kristen Barrish	Relative	Clerical	N/A	See Attached	3.39	8.48%	Alloc. Salary	3,816	21-7	6
7	Jeff Oravec	Shareholder	Administrative	0.41	See Attached	3.39	8.48%	Alloc. Salary	11,301	17-7	7
8	Tom Winter	Shareholder	Administrative	1.44	See Attached	5.09	8.48%	Alloc. Salary	16,950	17-7	8
9	Louise Bergthold	Shareholder	Administrative	4.94	See Attached	1.02	1.70%	Alloc. Salary	3,561	17-7	9
10	Joey Abramchik	Shareholder	Administrative	2.06	See Attached	3.81	8.47%	Alloc. Salary	16,018	17-7	10
11	Elka Abramchick	Relative	Clerical	N/A	See Attached	2.71	8.47%	Alloc. Salary	3,361	21-7	11
12	See second page 7 for the detail of the additional owner and related compensation								12,009		12
13								TOTAL	\$ 127,565		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization S.I.R. MANAGEMENT, INC.
Street Address 6840 N. LINCOLN
City / State / Zip Code LINCOLNWOOD, IL. 60712
Phone Number (847) 675 -7979
Fax Number (847) 675 -0555

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	6	REPAIRS AND MAINT.	PATIENT DAYS	837,569	13	\$ 133,007	\$ 59,965	70,985	\$ 11,273	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	837,569	13	10,563		70,985	895	2
3	10	NURSING	PATIENT DAYS	837,569	13	194,733	194,733	70,985	16,504	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	837,569	13	33,459		70,985	2,836	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	837,569	13	159,360	132,109	70,985	13,506	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	837,569	13	14,549		70,985	1,233	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	837,569	13	655,215	586,698	70,985	55,530	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	837,569	13	8,688		70,985	736	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	837,569	13	119,765		70,985	10,150	9
10	26	INSURANCE	PATIENT DAYS	837,569	13	18,080		70,985	1,532	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	837,569	13	57,453		70,985	4,869	11
12	32	INTEREST	PATIENT DAYS	837,569	13	(109,444)		70,985	(9,275)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	837,569	13	87,163		70,985	7,387	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	837,569	13	333,346	333,346	70,985	28,252	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	837,569	13	23,941		70,985	2,029	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	837,569	13	1,231,079	1,128,775	70,985	104,335	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	837,569	13	256,807		70,985	21,765	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,227,764	\$ 2,435,627		\$ 273,557	25

Facility Name & ID Number Elmwood Care# 0040410

Report Period Beginning:

01/01/11Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

S.I.R. MANAGEMENT, INC.

Street Address

6840 N. LINCOLN

City / State / Zip Code

LINCOLNWOOD, IL. 60712

Phone Number

(847) 675 -7979

Fax Number

(847) 675 -0555

	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	DIETARY SALARIES	PATIENT DAYS	837,569	13	\$ 91,408	\$ 91,408	70,985	\$ 7,747	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	837,569	13	15,892		70,985	1,347	2
3	10	NURSING SALARIES	PATIENT DAYS	837,569	13	95,082	95,082	70,985	8,058	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	837,569	13	16,460		70,985	1,395	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	837,569	13	971,606	971,606	70,985	82,345	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	837,569	13	189,000		70,985	16,018	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	837,569	13	219,385		70,985	18,593	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	315,820	13	123,146	123,146	29,400	11,464	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	315,820	13	20,802		29,400	1,937	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	367,402	13	344,256	344,256	18,561	17,392	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	367,402	13	69,007		18,561	3,486	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,880	13	32,378		1,092	2,745	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,880	13	13,246		1,092	1,123	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,880	13	705		1,092	60	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,880	13	899		1,092	76	19
20	26	INSURANCE	ALLOCATED SQ FT	12,880	13	1,527		1,092	129	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,880	13	103,394		1,092	8,766	21
22	32	INTEREST	ALLOCATED SQ FT	12,880	13	89,152		1,092	7,559	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,880	13	81,334		1,092	6,896	23
24	19	PROFESSIONAL FEES (RE TAX	ALLOCATED SQ FT	12,880	13	11,747		1,092	996	24
25	TOTALS					\$ 2,490,426	\$ 1,625,498		\$ 198,131	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization S.I.R. MANAGEMENT, INC.
Street Address 6840 N. LINCOLN
City / State / Zip Code LINCOLNWOOD, IL. 60712
Phone Number (847) 675 -7979
Fax Number (847) 675 -0555

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1										1
2	10	RESPIATORY CONSULTANT	LEASING INCOME	100	2	(27,000)		90	(24,300)	2
3	30	DEPRECIATION	LEASING INCOME	100	2	8,739		90	7,865	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					\$	\$		(16,435)	25

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Xcel Supply, LLC
Street Address 2201 Main Street
City / State / Zip Code Evanston, IL 60202
Phone Number (847)328-7600
Fax Number (847)328-7615

	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	Dietary	Direct Allocation			\$	\$			1
2	3	Housekeeping	Direct Allocation						42,580	2
3	4	Laundry	Direct Allocation						198	3
4	6	Repairs & Maintenance	Direct Allocation						759	4
5	10	Nursing	Direct Allocation						769,248	5
6	11	Activities	Direct Allocation							6
7	21	Office And Clerical	Direct Allocation							7
8	22	Employee Benefits	Direct Allocation							8
9	30	Fixed Assets-Depreciation	Direct Allocation						2,983	9
10	39	Ancillary	Direct Allocation							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					\$	\$		815,769	25

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization CCS Employee Benefits Group, Inc.
Street Address 2201 Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847)905-4000
Fax Number (847)905-4040

	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	22	Employee Health Insurance	Direct Allocation			\$	\$		\$ 105,822	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					\$	\$		\$ 105,822	25

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Midwest Bank		X	Mortgage			\$	14,084,553			\$ 956,674	1	
2	Other		X								11	2	
3												3	
4												4	
5	See Supplemental Schedule											5	
	Working Capital												
6	Lake Forest Bank		X	Line of Credit				4,350,000			145,136	6	
7												7	
8	See Supplemental Schedule							1,000,000				8	
9	TOTAL Facility Related						\$	19,434,553			\$ 1,101,822	9	
	B. Non-Facility Related*												
10	Interest Income		X								(1,409)	10	
11	Interest Income - Bldg. Co.	X									(2,305)	11	
12	SIR Management	X									(1,716)	12	
13	See Supplemental Schedule											13	
14	TOTAL Non-Facility Related						\$				\$ (5,430)	14	
15	TOTALS (line 9+line14)						\$	19,434,553			\$ 1,096,391	15	

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	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	SIR Management			Note Payable			\$	1,000,000				8	
9												9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital							1,000,000				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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.		\$	543,064	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.)		\$	451,654	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(91,410)	3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	467,000	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.)		\$	18,496	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.		\$	394,086	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	421,217	8	
		2007	468,669	9	
		2008	470,084	10	
		2009	521,243	11	
		2010	444,758	12	
2010 Accrual = \$444,758 x 1.05 = \$467,000					
Alloc. - SIR Management \$6,896					

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

FACILITY NAME	<u>Elmwood Care</u>	COUNTY	<u>Cook</u>
FACILITY IDPH LICENSE NUMBER	<u>0040410</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Steve Lavenda</u>		
TELEPHONE	(847) 236-1111	FAX #:	(847) 236-1155

Enter the tax index number and real estate tax assessed for 2010 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 2010.

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Elmwood Care</u>	COUNTY	<u>Cook</u>
---------------	---------------------	--------	-------------

FACILITY IDPH LICENSE NUMBER 0040410

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #:

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
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?

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,565

B. General Construction Type: Exterior Brick Frame _____ Number of Stories 4

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred: _____

2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____

4. Dates Incurred: _____

Nature of Costs: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1993</u>	<u>\$ 624,991</u>	<u>1</u>
2			<u>1998</u>	<u>100,000</u>	<u>2</u>
3	TOTALS			<u>\$ 724,991</u>	<u>3</u>

SEE ACCOUNTANTS' COMPILATION REPORT

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		2,720,857			136,043	136,043	231,795	67
68	Related Party Allocations (Pages 12H & 12I)		141,391	3,991		5,683	1,692	66,777	68
69	Financial Statement Depreciation			122,008			(122,008)		69
70	TOTAL (lines 4 thru 69)		\$ 14,946,616	\$ 546,177		\$ 528,898	\$ (17,279)	\$ 6,486,619	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 14,946,616	\$ 546,177		\$ 528,898	\$ (17,279)	\$ 6,486,619	1
2	Boiler Work	2008	10,825		20	541	541	2,165	2
3	Fire Door	2008	2,460		20	123	123	431	3
4	Curtains	2008	10,230		20	512	512	1,748	4
5	Flooring - Vinyl Rock / Gridstone Tiles	2008	3,320		20	166	166	540	5
6	Surveillance System	2008	3,424		20	171	171	556	6
7	Flooring - Vinyl	2008	4,400		20	220	220	715	7
8	Ejector Pump, Boiler, 7 Exhaust	2008	2,909		20	145	145	533	8
9	Sprinkler System	2008	6,566		20	328	328	1,067	9
10	Elevator Tracks	2008	7,056		20	353	353	1,235	10
11	Ejector Pumps / Piping	2008	5,323		20	266	266	1,042	11
12	Hvac Work	2009	10,548		20	527	527	1,582	12
13	Exhaust Fans	2009	11,567		20	578	578	1,735	13
14	Boiler Room Dampers	2009	4,983		20	249	249	685	14
15	Parking Lot	2009	37,500		20	1,875	1,875	4,688	15
16	Security System	2009	2,948		20	295	295	688	16
17	Outdoor Storage Building	2009	5,118		20	256	256	522	17
18	Outdoor Storage Building	2009	3,058		20	153	153	312	18
19	Window Treatments	2009	7,260		20	363	363	756	19
20	Walk-In Cooler Work	2009	9,538		20	477	477	1,351	20
21	Water Heater Repair	2009	4,125		20	206	206	584	21
22	Chiller Start-Up	2009	2,995		20	150	150	399	22
23	Rod Floor Drains	2009	3,056		20	153	153	407	23
24	Sprinkler Repair	2009	3,661		20	183	183	534	24
25	Ceiling Tile	2009	16,935		20	847	847	1,341	25
26	Painting	2010	6,150		20	308	308	615	26
27	Ventilator Alarm	2010	19,250		20	963	963	1,684	27
28	Fence And Gate	2010	3,374		20	169	169	295	28
29	Dialysis Renovation	2010	149,735		20	7,487	7,487	11,854	29
30	Fire Stopping	2010	7,000		20	350	350	467	30
31	Office Carpet	2010	3,496		20	175	175	320	31
32	Cubicle Curtains	2010	3,369		20	168	168	337	32
33	Lobby Drapes	2010	7,133		20	357	357	654	33
34	TOTAL (lines 1 thru 33)		\$ 15,325,928	\$ 546,177		\$ 548,011	\$ 1,834	\$ 6,528,462	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 15,325,928	\$ 546,177		\$ 548,011	\$ 1,834	\$ 6,528,462	1
2 Alarm System	2010	3,155		20	158	158	289	2
3 Boiler Work	2010	14,408		20	720	720	1,321	3
4 Custom Woodwork	2010	19,780		20	989	989	1,648	4
5 Trash Chute	2010	2,752		20	138	138	229	5
6 Walk-In Cooler Repair	2010	4,841		20	242	242	464	6
7 Replace Wallpaper	2010	2,600		20	130	130	238	7
8 Start Up Chiller	2010	4,547		20	227	227	379	8
9 Replace Locks	2010	3,181		20	159	159	292	9
10 Ventilators	2011	9,013		20	901	901	901	10
11 Window Screen Repairs	2011	2,886		20	144	144	144	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)		\$ 15,393,090	\$ 546,177		\$ 551,819	\$ 5,642	\$ 6,534,368	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12C, Carried Forward		\$ 15,393,090	\$ 546,177		\$ 551,819	\$ 5,642	\$ 6,534,368	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)		\$ 15,393,090	\$ 546,177		\$ 551,819	\$ 5,642	\$ 6,534,368	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 15,393,090	\$ 546,177		\$ 551,819	\$ 5,642	\$ 6,534,368	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)		\$ 15,393,090	\$ 546,177		\$ 551,819	\$ 5,642	\$ 6,534,368	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	HVAC Project	2008	1,560,000		20	78,000	78,000	156,000	9
10	Painting	2008	130,000		20	6,500	6,500	13,000	10
11	Elevator Cab	2008	43,612		20	2,181	2,181	4,362	11
12	Hand Rails	2008	15,105		20	755	755	1,510	12
13	Nurse Station	2008	112,920		20	5,646	5,646	11,292	13
14	Side Entry Hub	2008	8,245		20	412	412	824	14
15	Nurses Stations	2009	37,640		20	1,882	1,882	1,882	15
16	Window Treatement	2009	6,775		20	339	339	339	16
17	1st Floor Tile	2009	126,810		20	6,341	6,341	6,342	17
18	Resident Bathroom/Dayroom - Ceiling, Fixtures, Tiles, Paint	2009	202,085		20	10,104	10,104	10,104	18
19	Wiring	2009	10,034		20	502	502	2,756	19
20	Windows	2009	3,200		20	160	160	160	20
21	Lower Level Mall-Ceiling, Plumbing, Doors, Paint	2009	201,263		20	10,063	10,063	10,063	21
22	Painting	2009	15,000		20	750	750	750	22
23	Lower Level Mall-Drawings for Construction Permit	2009	9,000		20	450	450	450	23
24	2nd Floor Work	2009	23,400		20	1,170	1,170	1,170	24
25	2nd Floor Ceiling	2009	16,070		20	804	804	805	25
26	Sprinkler System Renovation	2009	11,017		20	551	551	551	26
27	Chair rail in dining Room	2009	11,312		20	566	566	566	27
28	Handrails - Floors 2,3,4	2009	44,652		20	2,233	2,233	2,233	28
29	Wallbase - Floors 2,3,4	2009	15,324		20	766	766	766	29
30	Tuckpointing	2011	61,030		20	3,052	3,052	3,052	30
31	Generator Project	2011	56,363		20	2,818	2,818	2,818	31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company Information Continued		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		\$ 2,720,857	\$		\$ 136,043	\$ 136,043	\$ 231,795	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Related Party Information		\$	\$		\$	\$	\$	1
2 Buildings:								2
3 SIR Properties - SIR Management	1993	38,378	1,218	35	1,097	(121)	19,189	3
4								4
5								5
6								6
7								7
8 Leasehold Improvements:								8
9 SIR Properties - SIR Management - Allocation	2010	2316		20	116	116	154	9
10 SIR Properties - SIR Management - Allocation	2009	2304	202	20	115	(87)	323	10
11 SIR Properties - SIR Management - Allocation	2007	672	55	20	34	(21)	168	11
12 SIR Properties - SIR Management - Allocation	2002	152		20	8	8	73	12
13 SIR Properties - SIR Management - Allocation	1999	4863		20	243	243	3,039	13
14 SIR Properties - SIR Management - Allocation	1998	2324		20	116	116	1,569	14
15 SIR Properties - SIR Management - Allocation	1997	145		20	7	7	112	15
16 SIR Properties - SIR Management - Allocation	1994	366	9	20	18	9	320	16
17 SIR Properties - SIR Management - Allocation	1993	622	3	20	31	28	576	17
18								18
19 SIR Management - Allocation	1993	9,730	271	20	483	212	9,173	19
20 SIR Management - Allocation	1994	30		20			30	20
21 SIR Management - Allocation	1995	222		20	11	11	183	21
22 SIR Management - Allocation	1997	14,951	335	20	734	399	11,066	22
23 SIR Management - Allocation	1999	1,176		20	59	59	720	23
24 SIR Management - Allocation	1999	13,707		20			11,917	24
25 SIR Management - Allocation	2000	1,388		20	69	69	802	25
26 SIR Management - Allocation	2007	4,460	412	20	223	(189)	936	26
27 SIR Management - Allocation	2008	12,290	1,175	20	775	(400)	2,981	27
28 SIR Management - Allocation	2009	30,539	280	20	1,528	1,248	3,430	28
29 SIR Management - Allocation	2011	756	31	20	16	(15)	16	29
30								30
31								31
32								32
33								33
34								34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		\$ 141,391	\$ 3,991		\$ 5,683	\$ 1,692	\$ 66,777	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$1,739,255	\$4,400	\$152,670	\$148,270	10	\$795,222	71
72	Current Year Purchases	192,007	7,682	19,829	12,147	10	65,555	72
73	Fully Depreciated Assets	1,220,840				10	485,840	73
74								74
75	TOTALS	\$3,152,102	\$12,082	\$172,499	\$160,417		\$1,346,616	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		Allocated - SIR Management	2010	\$2,980	\$367	\$422	\$55	5	\$591	76
77										77
78										78
79										79
80	TOTALS			\$2,980	\$367	\$422	\$55		\$591	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$19,273,163	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$558,626	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$724,740	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$166,114	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$7,881,575	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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:
- *

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: \$15,035
- Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2012	\$
13.	/2013	\$
14.	/2014	\$

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

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

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

☒ 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

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

		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)	\$			

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

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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 256,349	\$		\$ 256,349	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			165,052			165,052	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			313,085			313,085	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				363,393		363,393	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental			936,771		217,013	541,743		1,695,527	13
14	TOTAL			\$ 936,771		\$ 951,499	\$ 905,136		\$ 2,793,406	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 136,085	\$ 1,203,947	1
2	Cash-Patient Deposits	85,624	85,624	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,609,422	5,609,422	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	102,676	102,676	6
7	Other Prepaid Expenses	4,482	4,482	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule		129,807	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,938,289	\$ 7,135,958	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		727,991	13
14	Buildings, at Historical Cost		10,419,509	14
15	Leasehold Improvements, at Historical Cost	992,289	3,727,846	15
16	Equipment, at Historical Cost	2,673,881	4,029,991	16
17	Accumulated Depreciation (book methods)	(2,222,727)	(8,348,455)	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): See Attached Schedule			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,443,443	\$ 10,556,882	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,381,732	\$ 17,692,840	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 995,635	\$ 1,218,855	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	85,624	85,624	28
29	Short-Term Notes Payable	4,350,000	4,350,000	29
30	Accrued Salaries Payable	458,576	458,576	30
31	Accrued Taxes Payable (excluding real estate taxes)	48,737	48,737	31
32	Accrued Real Estate Taxes(Sch.IX-B)		467,000	32
33	Accrued Interest Payable		51,350	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	745,611	745,611	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,684,183	\$ 7,425,753	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,000,000	39
40	Mortgage Payable		14,084,553	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 15,084,553	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,684,183	\$ 22,510,306	46
47	TOTAL EQUITY(page 18, line 24)	\$ 697,549	\$ (4,817,466)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,381,732	\$ 17,692,840	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (645,432)	1
2	Restatements (describe):		2
3	<u>Rounding</u>	6	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (645,426)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,342,975	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	()	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)	\$ 1,342,975	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)	\$ 697,549	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 16,021,488	1
2	Discounts and Allowances for all Levels	(2,093,599)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,927,889	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,740,340	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,740,340	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	336,893	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	42,469	19
20	Radiology and X-Ray	5,405	20
21	Other Medical Services	756,329	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,141,096	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,409	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,409	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	340,254	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 340,254	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 18,150,988	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,126,516	31
32	Health Care	5,972,048	32
33	General Administration	3,265,668	33
	B. Capital Expense		
34	Ownership	2,218,803	34
	C. Ancillary Expense		
35	Special Cost Centers	2,837,840	35
36	Provider Participation Fee	387,138	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,808,013	40
41	Income before Income Taxes (line 30 minus line 40)**	1,342,975	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,342,975	43

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

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

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

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	985	1,332	\$ 65,942	\$ 49.51	1
2	Assistant Director of Nursing	3,353	3,675	144,916	39.43	2
3	Registered Nurses	37,798	40,638	1,240,335	30.52	3
4	Licensed Practical Nurses	45,327	48,263	1,306,399	27.07	4
5	CNAs & Orderlies	116,780	122,930	1,387,617	11.29	5
6	CNA Trainees					6
7	Licensed Therapist	38,241	40,544	936,771	23.11	7
8	Rehab/Therapy Aides	11,737	13,264	255,298	19.25	8
9	Activity Director	1,913	2,086	34,017	16.31	9
10	Activity Assistants	8,404	8,923	84,756	9.50	10
11	Social Service Workers	13,930	15,124	250,404	16.56	11
12	Dietician					12
13	Food Service Supervisor	3,929	4,284	74,912	17.49	13
14	Head Cook	5,340	5,863	60,281	10.28	14
15	Cook Helpers/Assistants	21,863	23,523	237,512	10.10	15
16	Dishwashers					16
17	Maintenance Workers	5,811	6,233	92,329	14.81	17
18	Housekeepers	26,237	28,977	275,363	9.50	18
19	Laundry	10,722	11,450	106,276	9.28	19
20	Administrator	3,774	4,171	242,007	58.02	20
21	Assistant Administrator	2,194	2,355	69,594	29.55	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,371	11,761	128,144	10.90	24
25	Vocational Instruction	558	558	2,301	4.12	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	7,827	8,604	162,883	18.93	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,301	3,620	70,224	19.40	33
34	TOTAL (lines 1 - 33)	381,395	408,178	\$ 7,228,281 *	\$ 17.71	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 36,108	01-03	35
36	Medical Director	Monthly	4,800	09-03	36
37	Medical Records Consultant	Monthly	4,512	10-03	37
38	Nurse Consultant	1,470	52,800	10-03	38
39	Pharmacist Consultant	Monthly	12,546	10-03	39
40	Physical Therapy Consultant	67	4,532	10a-03	40
41	Occupational Therapy Consultant	22	1,516	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	714	30,767	10a-03	43
44	Activity Consultant	Monthly	2,448	11-03	44
45	Social Service Consultant	69	3,599	12-03	45
46	Other(specify)				46
47	Director of Food Services	Monthly	29,400	01-03	47
48	Specialized Rehab Consultant	Monthly	29,400	10a-03	48
49	TOTAL (lines 35 - 48)	2,342	\$ 212,428		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberElmwood Care# 0040410Report Period Beginning:01/01/11Ending:12/31/11

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Arleen Manchavez-Siap	Administrator	0.00%	\$ 115,410	Workers' Compensation Insurance	\$ 197,708	IDPH License Fee	\$ 3,731	
Mark Solomon	Administrator	0.00%	126,596	Unemployment Compensation Insurance	91,683	Advertising: Employee Recruitment	20,829	
Monique Jones-Stafford	Asst. Admin	0.00%	1,260	FICA Taxes	546,756	Health Care Worker Background Check		
Khaled Mohammed	Asst. Admin	0.00%	3,458	Employee Health Insurance	185,843	(Indicate # of checks performed 182)	1,820	
Irma Olson	Asst. Admin	0.00%	64,876	Employee Meals	44,983	Patient Background Checks	895.88,958	
				Illinois Municipal Retirement Fund (IMRF)*		Advertising	9,316	
				Pension Plan	46,437	Dues & Subscriptions	15,950	
				401k Contribution	10,670	Licenses and Permits	1,146	
				Employee Benefits - Other	12,068	Alloc-SIR Management	1,233	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)								
\$ 311,601								
B. Administrative - Other								
Description			Amount					
S.I.R. Mangement - Dir. Of Administrative Services			\$ 58,800			Less: Public Relations Expense	()	
S.I.R. Mangement -Ancillary Charges			58,800			Non-allowable advertising	(9,316)	
S.I.R. Management - Consulting Fee			492,611			Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
(Attach a copy of any management service agreement)				\$ 1,136,147		\$ 53,668		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Frost, Ruttenberg, & Rothblatt	Accounting		\$ 22,074			\$	Out-of-State Travel	\$
S.I.R. Management	Accounting		36,000					
S.I.R. Management	Dir. Of Regulatory Serv.		29,400					
S.I.R. Management	Bookkeeping		108,780				In-State Travel	
Personnel Planners	Unemployment Tax Consult.		3,778					
E-Health Data Solutions	Data Processing		3,600					
Pinnacle Consulting	Cust. Satisfaction Survey		3,130					
Patient Systems	Software Subscription Fee		3,900					
Honkemp Kruegar	Tax Credit Programs		2,465				Seminar Expense	3,465
Hamlin & Burton	Liability Management		600				Alloc.-SIR Management	736
Property Valuation Services	Appraisal Service		2,500					
See Supplemental Schedule			32,745					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			Entertainment Expense ()	
(If total legal fees exceed \$5,000, attach copy of invoices.)				\$			(agree to Sch. V, line 24, col. 8)	
\$ 248,971							\$ 4,201	

* Attach copy of IMRF notifications

SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 - \$21,261.74

(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. \$ 10,511 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. \$ 387,138
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 44,983 Has any meal income been offset against related costs? N/A 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 4

d. Have vehicle usage logs been maintained? N/A

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A

g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT