FOR BHF USE

LL1

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

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0040410

Facility Name: Elmwood Care

Address: 7733 W. Grand Ave . (Number) Elmwood Park (City) 60635 (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	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/12 to 12/31/12 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: 01/01/12 Ending: 12/31/12

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	245	Skilled (SNF)	245	89,670	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	245	TOTALS	245	89,670	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	62,040	3,028	8,128	73,196	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	62,040	3,028	8,128	73,196	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.63%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 4/1/1993

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/1/1993 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 245 and days of care provided 5,498

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	374,255	58,186	65,476	497,917		497,917	(21,696)	476,221			1
2	Food Purchase		354,059		354,059	(40,538)	313,521	(146)	313,375			2
3	Housekeeping	284,273	100,862		385,135		385,135		385,135			3
4	Laundry	103,088	48,014		151,102		151,102		151,102			4
5	Heat and Other Utilities			244,926	244,926		244,926	(11,464)	233,462			5
6	Maintenance	91,510	54,791	290,369	436,670		436,670	(19,999)	416,671			6
7	Other (specify):*							5,081	5,081			7
8	TOTAL General Services	853,126	615,912	600,771	2,069,809	(40,538)	2,029,271	(48,224)	1,981,047			8
	B. Health Care and Programs											
9	Medical Director			10,800	10,800		10,800		10,800			9
10	Nursing and Medical Records	4,326,420	853,815	88,814	5,269,049		5,269,049	(242,692)	5,026,357			10
10a	Therapy	282,056		55,938	337,994		337,994	(12,203)	325,791			10a
11	Activities	130,106	9,869	2,244	142,219		142,219		142,219			11
12	Social Services	274,190		3,675	277,865		277,865		277,865			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							6,170	6,170			15
16	TOTAL Health Care and Programs	5,012,772	863,684	161,471	6,037,927		6,037,927	(248,725)	5,789,202			16
	C. General Administration											
17	Administrative	281,890		940,374	1,222,264		1,222,264	(824,892)	397,372			17
18	Directors Fees											18
19	Professional Services			276,913	276,913	(9,492)	267,421	(159,711)	107,710			19
20	Dues, Fees, Subscriptions & Promotions			50,900	50,900		50,900	(27,449)	23,451			20
21	Clerical & General Office Expenses	202,069	50,045	903,902	1,156,016		1,156,016	(676,655)	479,361			21
22	Employee Benefits & Payroll Taxes			1,135,181	1,135,181	40,538	1,175,719		1,175,719			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,302	7,302		7,302	702	8,004			24
25	Other Admin. Staff Transportation			4,160	4,160		4,160	10,566	14,726			25
26	Insurance-Prop.Liab.Malpractice			174,260	174,260		174,260	1,745	176,005			26
27	Other (specify):*							51,838	51,838			27
28	TOTAL General Administration	483,959	50,045	3,492,992	4,026,996	31,046	4,058,042	(1,623,856)	2,434,186			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,349,857	1,529,641	4,255,234	12,134,732	(9,492)	12,125,240	(1,920,805)	10,204,435			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			117,383	117,383		117,383	611,486	728,869			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			109,474	109,474		109,474	885,615	995,089			32
33	Real Estate Taxes			28,638	28,638	9,492	38,130	425,376	463,506			33
34	Rent-Facility & Grounds			1,944,000	1,944,000		1,944,000	(1,944,000)				34
35	Rent-Equipment & Vehicles			7,282	7,282		7,282	6,741	14,023			35
36	Other (specify):*											36
37	TOTAL Ownership			2,206,777	2,206,777	9,492	2,216,269	(14,782)	2,201,487			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	947,916	616,527	923,743	2,488,186		2,488,186		2,488,186			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			538,657	538,657		538,657		538,657			42
43	Other (specify):*	17,970			17,970		17,970	(17,970)				43
44	TOTAL Special Cost Centers	965,886	616,527	1,462,400	3,044,813		3,044,813	(17,970)	3,026,843			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,315,743	2,146,168	7,924,411	17,386,322		17,386,322	(1,953,557)	15,432,765			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(14,066)	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	170,500	30		9
10	Interest and Other Investment Income	(489)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(146)	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	(4,650)	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	(755,956)	21		24
25	Fund Raising, Advertising and Promotional	(13,117)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(9,500)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(154,904)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (782,328)		$	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)	(1,171,229)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,171,229)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,953,557)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Elmwood Care

ID# 0040410

Report Period Beginning: 01/01/12

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Therapy Expenses - VA	$ (62,736)	10	1
2	Misc. Income	(17)	21	2
3	Other Professional-Lobbying	(433)	19	3
4	Bank Fees	(6,038)	21	4
5	COPE Dues	(10,196)	20	5
6	Marketing Salaries	(17,970)	43	6
7	Collections	(9,212)	21	7
8	Non-Allowable Legal	(7,720)	19	8
9	Additional R&M	1,441	06	9
10	Filing Fees - Building Co.	(525)	21	10
11	Amortization - Building Co.	(18,765)	36	11
12	Office Expense - Building Co.	(1,016)	21	12
13	Capitalized R&M	(3,248)	06	13
14	Professional Fees - Building Co.	(17,072)	19	14
15	Oxygen Expense	(915)	10	15
16	Theft & Damage	(482)	21	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**	(154,904)		49

Elmwood Care

ID# 0040410

Report Period Beginning: 01/01/12

Ending: 12/31/12

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

STATE OF ILLINOIS **Summary A**

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

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				(21,696)								(21,696)	1
2	Food Purchase	(146)											(146)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(14,066)			2,602								(11,464)	5
6	Maintenance	(1,807)		(19,877)	1,685								(19,999)	6
7	Other (specify):*			746	4,335								5,081	7
8	**TOTAL General Services**	(16,019)		(19,131)	(13,074)								(48,224)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(63,651)		(53,477)	8,515	(134,079)							(242,692)	10
10a	Therapy				(12,203)								(12,203)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			2,873	3,297								6,170	15
16	**TOTAL Health Care and Programs**	(63,651)		(50,604)	(391)	(134,079)							(248,725)	16
	C. General Administration													
17	Administrative			(911,268)	86,376								(824,892)	17
18	Directors Fees													18
19	Professional Services	(25,225)	26,564	(177,627)	16,577								(159,711)	19
20	Fees, Subscriptions & Promotions	(27,963)		514									(27,449)	20
21	Clerical & General Office Expenses	(782,746)	1,541	104,471	79								(676,655)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			702									702	24
25	Other Admin. Staff Transportation			10,566									10,566	25
26	Insurance-Prop.Liab.Malpractice			1,608	137								1,745	26
27	Other (specify):*			33,003	18,835								51,838	27
28	**TOTAL General Administration**	(835,934)	28,105	(938,031)	122,004								(1,623,856)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(915,604)	28,105	(1,007,766)	108,539	(134,079)							(1,920,805)	29

STATE OF ILLINOIS **Summary B**

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

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	170,500	424,161		9,937	6,888							611,486	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(489)	887,602	(8,838)	7,340								885,615	32
33	Real Estate Taxes		421,446		3,930								425,376	33
34	Rent-Facility & Grounds		(1,944,000)										(1,944,000)	34
35	Rent-Equipment & Vehicles			6,741									6,741	35
36	Other (specify):*	(18,765)	18,765											36
37	**TOTAL Ownership**	151,246	(192,026)	(2,097)	21,207	6,888							(14,782)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(17,970)											(17,970)	43
44	**TOTAL Special Cost Centers**	(17,970)											(17,970)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(782,328)	(163,921)	(1,009,863)	129,746	(127,191)							(1,953,557)	45

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

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
					Elmwood Grand, LLC				
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%	18,765	18,765	2
3	V	30	Depreciation		Elmwood Grand, LLC	100.00%	424,161	424,161	3
4	V	21	Filing Fees		Elmwood Grand, LLC	100.00%	525	525	4
5	V	32	Interest	3,053	Elmwood Grand, LLC	100.00%	890,655	887,602	5
6	V	21	Office Expense		Elmwood Grand, LLC	100.00%	1,016	1,016	6
7	V	19	Professional Fees		Elmwood Grand, LLC	100.00%	17,072	17,072	7
8	V	33	Real Estate Taxes		Elmwood Grand, LLC	100.00%	421,446	421,446	8
9	V	19	Real Estate Taxe- Legal Fees		Elmwood Grand, LLC	100.00%	9,492	9,492	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,947,053			$ 1,783,132	$ * (163,921)	14

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

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS AND MAINT.	$ 29,400	S.I.R. MANAGEMENT, INC.	100.00%	$ 9,523	$ (19,877)	15
16	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	746	746	16
17	V	10	NURSING	70,560	S.I.R. MANAGEMENT, INC.	100.00%	17,083	(53,477)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	2,873	2,873	18
19	V	19	PROFESSIONAL FEES	191,820	S.I.R. MANAGEMENT, INC.	100.00%	13,953	(177,867)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	514	514	20
21	V	21	CLERICAL & GENERAL	70,560	S.I.R. MANAGEMENT, INC.	100.00%	65,157	(5,403)	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	702	702	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	10,566	10,566	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,608	1,608	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	11,529	11,529	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(8,838)	(8,838)	26
27	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	6,741	6,741	27
28	V								28
29	V	17	ADMINISTRATIVE	940,374	S.I.R. MANAGEMENT, INC.	100.00%	29,106	(911,268)	29
30	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	240	240	30
31	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	109,874	109,874	31
32	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	21,474	21,474	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,302,714			$ 292,851	$ * (1,009,863)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 29,400	S.I.R. MANAGEMENT, INC.	100.00%	$ 7,704	$ (21,696)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,307	1,307	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	8,515	8,515	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	1,433	1,433	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	86,376	86,376	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	16,515	16,515	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	18,835	18,835	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	23,520	S.I.R. MANAGEMENT, INC.	100.00%	11,317	(12,203)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,864	1,864	25
26	V								26
27	V	6	MAINTENANCE SALARIES	15,571	S.I.R. MANAGEMENT, INC.	100.00%	16,651	1,080	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	3,028	3,028	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	2,602	2,602	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	605	605	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	62	62	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	79	79	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	137	137	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	9,937	9,937	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	7,340	7,340	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	3,930	3,930	37
38	V								38
39	Total			$ 68,491			$ 198,237	$ * 129,746	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	RESPITORY CONSULTANT	97,568	S.I.R. MANAGEMENT, INC.	100.00%	(36,511)	$ (134,079)	15
16	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	6,888	6,888	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			$ 97,568			$ (29,623)	$ * (127,191)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 90,377	$ 90,377	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	90,377	CCS Employee Benefits Group	100.00%		(90,377)	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			$ 90,377			$ 90,377	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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%	APPLEWOOD REHABILITATION CENTER,LLC	MATTESON	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	2
3	CELESTE GIANNINI TRUST DTD 3/13/00	17.747%	BRYN MAWR CARE INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	DANIEL ROTHNER TRUST	2.881%	COLUMBUS PARK NURSING & REHABILITATION CENTER, INC.	CHICAGO	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	4
5	DENNIS TOSSI	0.823%	DECATUR MANOR HEALTHCARE,LLC	DECATUR				5
6	GALE ROTHNER	9.465%	FAIRVIEW NURSING PLAZA, INC.	ROCKFORD				6
7	HARVEY SCOTT	0.823%	GREENWOOD CARE, INC.	EVANSTON				7
8	JEFF ORAVEC	0.412%	MAPLEWOOD CARE, INC.	ELGIN				8
9	JOEY ABRAMCHIK	2.058%	NEIGHBORS REHABILITATION CENTER,LLC	BYRON				9
10	JULIANA R. BARRISH TRUST DTD 1/26/93	14.249%	REGENCY REHABILITATION CENTER,LLC	NILES				10
11	KATHRYN VALES TRUST	2.881%	ROCK ISLAND NURSING & REHAB CENTER,LLC	ROCK ISLAND				11
12	KIMBERLY RICHMAN TRUST	2.881%	WILSON CARE, INC.	CHICAGO				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

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

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

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	David Winter	Relative	Clerical	N/A	See Attached	0.56	8.62%	Alloc. Salary	$ 291	21-7	1
2	Bryan Barrish	Relative	Administrative	N/A	See Attached	3.43	7.62%	Alloc. Salary	17,162	17-7	2
3	Michael Giannini	Relative	Administrative	N/A	See Attached	3	7.50%	Alloc. Salary	14,416	17-7	3
4	Nenita Guzman	Relative	Dietary	N/A	See Attached	4.29	8.58%	Alloc. Salary	7,704	1-7	4
5	Sarah Barrish	Relative	Administrative	N/A	See Attached	4.29	8.58%	Alloc. Salary	10,378	17-7	5
6	Kristen Barrish	Relative	Clerical	N/A	See Attached	3.43	8.58%	Alloc. Salary	3,998	21-7	6
7	Jeff Oravec	Shareholder	Administrative	0.41	See Attached	3.43	8.58%	Alloc. Salary	11,944	17-7	7
8	Tom Winter	Shareholder	Administrative	1.44	See Attached	5.15	8.58%	Alloc. Salary	17,162	17-7	8
9	Louise Bergthold	Shareholder	Administrative	4.94	See Attached	5.15	8.58%	Alloc. Salary	17,162	17-7	9
10	Joey Abramchik	Shareholder	Administrative	2.06	See Attached	3.86	8.58%	Alloc. Salary	16,515	17-7	10
11	Elka Abramchick	Relative	Clerical	N/A	See Attached	2.75	8.59%	Alloc. Salary	3,803	21-7	11
12	See second page 7 for the detail of the additional owner and related compensation								1,171		12
13								TOTAL	$ 121,706		13

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

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

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: 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	6	REPAIRS AND MAINT.	PATIENT DAYS	852,976	13	$ 110,978	$ 47,841	73,196	$ 9,523	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	852,976	13	8,688		73,196	746	2
3	10	NURSING	PATIENT DAYS	852,976	13	199,072	199,072	73,196	17,083	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	852,976	13	33,485		73,196	2,873	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	852,976	13	162,603	94,013	73,196	13,953	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	852,976	13	5,990		73,196	514	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	852,976	13	759,296	684,975	73,196	65,157	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	852,976	13	8,182		73,196	702	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	852,976	13	123,128		73,196	10,566	9
10	26	INSURANCE	PATIENT DAYS	852,976	13	18,740		73,196	1,608	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	852,976	13	134,350		73,196	11,529	11
12	32	INTEREST	PATIENT DAYS	852,976	13	(102,988)		73,196	(8,838)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	852,976	13	78,558		73,196	6,741	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	852,976	13	339,187	339,187	73,196	29,106	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	852,976	13	2,801		73,196	240	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	852,976	13	1,280,400	1,178,532	73,196	109,874	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	852,976	13	250,244		73,196	21,474	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,412,714	$ 2,543,620		$ 292,851	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: 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	852,976	13	$ 89,778	$ 89,778	73,196	$ 7,704	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	852,976	13	15,225		73,196	1,307	2
3	10	NURSING SALARIES	PATIENT DAYS	852,976	13	99,226	99,226	73,196	8,515	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	852,976	13	16,696		73,196	1,433	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	852,976	13	1,006,570	1,006,570	73,196	86,376	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	852,976	13	192,450		73,196	16,515	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	852,976	13	219,485		73,196	18,835	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	288,024	13	138,589	138,589	23,520	11,317	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	288,024	13	22,823		23,520	1,864	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	401,695	13	429,544	429,544	15,571	16,651	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	401,695	13	78,117		15,571	3,028	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	13	30,330		1,105	2,602	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	13	7,048		1,105	605	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	13	717		1,105	62	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	13	925		1,105	79	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	13	1,601		1,105	137	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	13	115,812		1,105	9,937	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	13	85,544		1,105	7,340	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	13	45,809		1,105	3,930	23
24										24
25	TOTALS					$ 2,596,289	$ 1,763,707		$ 198,237	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: 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	10	RESPITORY CONSULTANT	LEASING INCOME	100	2	(40,568)		90	(36,511)	1
2	30	DEPRECIATION	LEASING INCOME	100	2	7,653		90	6,888	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					$	$		$ (29,623)	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: 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			$	$		$ 90,377	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					$	$		$ 90,377	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Midwest Bank		X	Mortgage			$	$ 14,900,000			$ 890,654	1
2	Other		X								639	2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Lake Forest Bank		X	Line of Credit				3,080,000			108,834	6
7	SIR Management			Note Payable				1,000,000				7
8	See Supplemental Schedule										7,340	8
9	TOTAL Facility Related						$	$ 18,980,000			$ 1,007,468	9
	B. Non-Facility Related*											
10	Interest Income		X								(489)	10
11	Interest Income - Bldg. Co.	X									(3,053)	11
12	SIR Management	X									(8,838)	12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (12,380)	14
15	TOTALS (line 9+line14)						$	$ 18,980,000			$ 995,088	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.)**

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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	X					$	$			$ 7,340	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										7,340	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 467,000	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.)		$ 451,014	2
3. Under or (over) accrual (line 2 minus line 1).		$ (15,986)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 470,000	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.**		$ 9,492	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** $ 28,638 **For** 2007 **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.		$ 463,506	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	468,669	8
	2008	470,084	9
	2009	521,243	10
	2010	444,758	11
	2011	447,084	12

2012 Accrual = $447,084 x 1.05 = $470,000 (rounded)

Alloc. - SIR Management $3,930

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Elmwood Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040410

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-25-323-003-0000	Long Term Care Property	$ 122,611.37	$ 122,611.37
2.	12-25-323-004-0000	Long Term Care Property	$ 122,490.96	$ 122,490.96
3.	12-25-323-005-0000	Long Term Care Property	$ 191,752.67	$ 191,752.67
4.	12-25-324-001-0000	Long Term Care Property	$ 5,530.45	$ 5,530.45
5.	12-25-324-002-0000	Long Term Care Property	$ 4,699.01	$ 4,699.01
6.	See Attaached	See Attached	$ 101,165.17	$ 6,797.66
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 548,249.63	$ 453,882.12

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Elmwood Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040410

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE ( ) _____ FAX #: ( ) _____

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

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

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

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 [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

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

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

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

None

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	245			1975	$ 10,419,509	$ 257,160	35	$ 297,700	$ 40,540	$ 5,464,049	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	129,203		20	6,460	6,460	124,587	9
10	Various			1994	49,738		20	2,487	2,487	46,115	10
11	Various			1995	167,102		20	8,355	8,355	146,510	11
12	Various			1996	136,090		20	6,805	6,805	111,338	12
13	Various			1997	16,180		20	809	809	12,577	13
14	Various			1998	158,155		20	6,538	6,538	121,460	14
15	Various			1999	121,088		20	6,054	6,054	81,930	15
16	Various			2000	67,583		20	3,379	3,379	42,111	16
17	Various			2001	107,654		20	5,383	5,383	62,427	17
18	Various			2002	113,214		20	5,970	5,970	110,833	18
19	Various			2003	145,109		20	7,809	7,809	73,763	19
20	Various			2004	124,757		20	5,954	5,954	53,430	20
21	Various			2005	84,119		20	4,706	4,706	36,846	21
22	Various			2006	127,687		20	6,917	6,917	44,213	22
23	Various			2007	117,180		20	6,773	6,773	37,959	23
24	Various			2008	56,513		20	2,826	2,826	12,857	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		2,720,857	105,281		136,043	30,762	625,926	67
68	Related Party Allocations (Pages 12H & 12I)		169,198	5,228		6,403	1,175	77,805	68
69	Financial Statement Depreciation			117,383			(117,383)		69
70	TOTAL (lines 4 thru 69)		$ 15,030,936	$ 485,052		$ 527,372	$ 42,320	$ 7,286,735	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: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 15,030,936	$ 485,052		$ 527,372	$ 42,320	$ 7,286,735	1
2	Hvac Work	2009	10,548		20	527	527	2,110	2
3	Exhaust Fans	2009	11,567		20	578	578	2,313	3
4	Boiler Room Dampers	2009	4,983		20	249	249	934	4
5	Parking Lot	2009	37,500		20	1,875	1,875	6,563	5
6	Security System	2009	2,948		20	295	295	983	6
7	Outdoor Storage Building	2009	5,118		20	256	256	778	7
8	Outdoor Storage Building	2009	3,058		20	153	153	465	8
9	Window Treatments	2009	7,260		20	363	363	1,119	9
10	Walk-In Cooler Work	2009	9,538		20	477	477	1,828	10
11	Water Heater Repair	2009	4,125		20	206	206	791	11
12	Chiller Start-Up	2009	2,995		20	150	150	549	12
13	Rod Floor Drains	2009	3,056		20	153	153	560	13
14	Sprinkler Repair	2009	3,661		20	183	183	717	14
15	Ceiling Tile & Lighting	2009	16,935		20	1,694	1,694	5,222	15
16	Painting	2010	6,150		20	308	308	923	16
17	Ventilator Alarm	2010	19,250		20	963	963	2,647	17
18	Fence And Gate	2010	3,374		20	169	169	464	18
19	Dialysis Renovation	2010	149,735		20	7,487	7,487	19,341	19
20	Fire Stopping	2010	7,000		20	350	350	817	20
21	Office Carpet	2010	3,496		20	175	175	495	21
22	Cubicle Curtains	2010	3,369		20	168	168	505	22
23	Lobby Drapes	2010	7,133		20	357	357	1,011	23
24	Alarm System	2010	3,155		20	158	158	447	24
25	Boiler Work	2010	14,408		20	720	720	2,041	25
26	Custom Woodwork	2010	19,780		20	989	989	2,637	26
27	Trash Chute	2010	2,752		20	138	138	367	27
28	Walk-In Cooler Repair	2010	4,841		20	242	242	706	28
29	Replace Wallpaper	2010	2,600		20	130	130	368	29
30	Start Up Chiller	2010	4,547		20	227	227	606	30
31	Replace Locks	2010	3,181		20	159	159	451	31
32	Ventilators	2011	9,013		20	901	901	1,803	32
33	Window Screen Repairs	2011	2,886		20	144	144	180	33
34	TOTAL (lines 1 thru 33)		$ 15,420,898	$ 485,052		$ 548,315	$ 63,263	$ 7,347,475	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: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 15,420,898	$ 485,052		$ 548,315	$ 63,263	$ 7,347,475	1
2	Hallway Cabinetry	2012	2,880		20	132	132	132	2
3	Sprinkler Heads	2012	3,430		20	143	143	143	3
4	Sewage Pump	2012	4,395		20	201	201	201	4
5	Security Camera System	2012	9,153		20	420	420	420	5
6	Therapy Room Cabinetry	2012	9,800		20	327	327	327	6
7	Storage Room Cabinetry	2012	6,000		20	125	125	125	7
8	Fire Duct Detectors	2012	4,646		20	58	58	58	8
9	Boiler Work	2012	6,382		20	53	53	53	9
10	Install Handrails, Corner Guards And Crashrails	2012	3,248		20	162	162	162	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)		$ 15,470,832	$ 485,052		$ 549,936	$ 64,884	$ 7,349,097	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: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 15,470,832	$ 485,052		$ 549,936	$ 64,884	$ 7,349,097	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)		$ 15,470,832	$ 485,052		$ 549,936	$ 64,884	$ 7,349,097	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: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 15,470,832	$ 485,052		$ 549,936	$ 64,884	$ 7,349,097	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)		$ 15,470,832	$ 485,052		$ 549,936	$ 64,884	$ 7,349,097	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: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	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	39,000	20	78,000	39,000	390,000	9
10	Painting	2008	130,000	13,000	20	6,500	(6,500)	32,500	10
11	Elevator Cab	2008	43,612	2,181	20	2,181	(0)	10,903	11
12	Hand Rails	2008	15,105	1,511	20	755	(756)	3,776	12
13	Nurse Station	2008	112,920		20	5,646	5,646	28,230	13
14	Side Entry Hub	2008	8,245	825	20	412	(413)	2,061	14
15	Nurses Stations	2009	37,640	1,882	20	1,882		7,528	15
16	Window Treatement	2009	6,775	677	20	339	(338)	1,355	16
17	1st Floor Tile	2009	126,810	6,341	20	6,341	(1)	25,362	17
18	Resident Bathroom/Dayroom - Ceiling, Fixtures, Tiles, Paint	2009	202,085	10,104	20	10,104	0	40,417	18
19	Wiring	2009	10,034		20	502	502	2,007	19
20	Windows	2009	3,200	320	20	160	(160)	640	20
21	Lower Level Mall-Ceiling, Plumbing, Doors, Paint	2009	201,263	10,063	20	10,063	0	40,253	21
22	Painting	2009	15,000	1,500	20	750	(750)	3,000	22
23	Lower Level Mall-Drawings for Construction Permit	2009	9,000	450	20	450		1,800	23
24	2nd Floor Work	2009	23,400	1,170	20	1,170		4,680	24
25	2nd Floor Ceiling	2009	16,070	804	20	804	(1)	3,214	25
26	Sprinkler System Renovation	2009	11,017	551	20	551	(0)	2,203	26
27	Chair rail in dining Room	2009	11,312	566	20	566	(0)	2,262	27
28	Handrails - Floors 2,3,4	2009	44,652	2,233	20	2,233	(0)	8,930	28
29	Wallbase - Floors 2,3,4	2009	15,324	766	20	766	0	3,065	29
30	Tuckpointing	2011	61,030	1,526	20	3,052	1,526	6,103	30
31	Generator Project	2011	56,363	2,818	20	2,818	0	5,636	31
32	Additional Depreciation			6,993			(6,993)		32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	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	$ 105,281		$ 136,043	$ 30,762	$ 625,926	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: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	SIR Properties - SIR Management	2009	21,450		35	550	550	1,673	3
4	SIR Properties - SIR Management	1993	38,838	1,233	35	1,110	(123)	21,638	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Alloc. - S.I.R. Management	1993	9,847	274	20	488	214	9,763	9
10	Alloc. - S.I.R. Management	1994	31		20			31	10
11	Alloc. - S.I.R. Management	1995	225		20	11	11	196	11
12	Alloc. - S.I.R. Management	1997	15,130	339	20	742	403	11,931	12
13	Alloc. - S.I.R. Management	1999	1,190		20	60	60	788	13
14	Alloc. - S.I.R. Management	1999	13,707		20			13,707	14
15	Alloc. - S.I.R. Management	2000	1,405		20	70	70	881	15
16	Alloc. - S.I.R. Management	2007	4,513	308	20	224	(84)	1,165	16
17	Alloc. - S.I.R. Management	2008	12,437	1,188	20	779	(409)	3,774	17
18	Alloc. - S.I.R. Management	2009	30,905	281	20	1,535	1,254	4,982	18
19	Alloc. - S.I.R. Management	2011	765	76	20	76		108	19
20	Alloc. - S.I.R. Management	2012	2,447	51	20	51		51	20
21									21
22	Alloc. - S.I.R. Properties - S.I.R. Management	2012	2,379	1,266	20	11	(1,255)	11	22
23	Alloc. - S.I.R. Properties - S.I.R. Management	2010	2,344		20	117	117	273	23
24	Alloc. - S.I.R. Properties - S.I.R. Management	2009	2,332	146	20	117	(29)	443	24
25	Alloc. - S.I.R. Properties - S.I.R. Management	2007	680	54	20	34	(20)	204	25
26	Alloc. - S.I.R. Properties - S.I.R. Management	2002	154		20	8	8	81	26
27	Alloc. - S.I.R. Properties - S.I.R. Management	1999	4,921		20	246	246	3,322	27
28	Alloc. - S.I.R. Properties - S.I.R. Management	1998	2,352		20	118	118	1,705	28
29	Alloc. - S.I.R. Properties - S.I.R. Management	1997	146		20	7	7	121	29
30	Alloc. - S.I.R. Properties - S.I.R. Management	1994	370	9	20	18	9	342	30
31	Alloc. - S.I.R. Properties - S.I.R. Management	1993	630	3	20	31	28	615	31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	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)		$ 169,198	$ 5,228		$ 6,403	$ 1,175	$ 77,805	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: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,589,375	$ 65,829	$ 164,447	$ 98,618	10	$ 959,717	71
72	Current Year Purchases	39,416	173	2,046	1,873	10	2,046	72
73	Fully Depreciated Assets	563,951	6,888	11,983	5,095	10	563,951	73
74								74
75	TOTALS	$ 3,192,742	$ 72,890	$ 178,476	$ 105,586		$ 1,525,714	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 from SIR Management	2011	$ 3,016	$ 427	$ 457	$ 30	5	$ 1,055	76
77										77
78										78
79										79
80	TOTALS			$ 3,016	$ 427	$ 457	$ 30		$ 1,055	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 19,391,581	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 558,369	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 728,869	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 170,500	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 8,875,866	85	

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

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

G. Construction-in-Progress

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

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ 14,023 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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care | STATE OF ILLINOIS # 0040410 | Report Period Beginning: 01/01/12 Ending: 12/31/12

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	$		$ 265,526	$		$ 265,526	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			190,181			190,181	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			274,184			274,184	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				214,107		214,107	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental			947,916		193,852	402,420		1,544,188	13
14	TOTAL			$ 947,916		$ 923,743	$ 616,527		$ 2,488,186	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

STATE OF ILLINOIS

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

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/12 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 4,831	$ 2,433,445	1
2	Cash-Patient Deposits	81,869	81,869	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,661,450	4,661,450	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	101,625	101,625	6
7	Other Prepaid Expenses	2,490	2,490	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,852,265	$ 7,280,879	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	1,054,472	3,790,029	15
16	Equipment, at Historical Cost	2,696,836	4,052,946	16
17	Accumulated Depreciation (book methods)	(2,340,110)	(8,889,999)	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		103,590	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,411,198	$ 10,204,066	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,263,463	$ 17,484,945	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 901,133	$ 1,067,706	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	81,870	81,870	28
29	Short-Term Notes Payable	3,080,000	3,080,000	29
30	Accrued Salaries Payable	517,546	517,546	30
31	Accrued Taxes Payable (excluding real estate taxes)	130,748	130,748	31
32	Accrued Real Estate Taxes(Sch.IX-B)		470,000	32
33	Accrued Interest Payable		36,004	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	617,192	617,192	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,328,489	$ 6,001,066	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,000,000	39
40	Mortgage Payable		14,900,000	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)**	$	$ 15,900,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,328,489	$ 21,901,066	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 934,974	$ (4,416,121)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,263,463	$ 17,484,945	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 697,549	1
2	Restatements (describe):		2
3	Rounding	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 697,551	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	601,923	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	(364,500)	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)**	$ 237,423	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)**	$ 934,974	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 16,028,792	1
2	Discounts and Allowances for all Levels	(2,477,575)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,551,217	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,814,240	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,814,240	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	209,070	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,125	19
20	Radiology and X-Ray	3,805	20
21	Other Medical Services	774,031	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,009,031	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	489	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 489	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	613,268	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 613,268	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,988,245	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,069,809	31
32	Health Care	6,037,927	32
33	General Administration	4,026,996	33
	B. Capital Expense		
34	Ownership	2,206,777	34
	C. Ancillary Expense		
35	Special Cost Centers	2,506,156	35
36	Provider Participation Fee	538,657	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,386,322	40
41	**Income before Income Taxes (line 30 minus line 40)****	601,923	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 601,923	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 11,901,325	44
45	Private Pay - Net Inpatient Revenue	642,311	45
46	Medicare - Net Inpatient Revenue	389,805	46
47	Other-(specify) VA	304,779	47
48	Other-(specify) Hospice/HMO/Ins	312,997	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 13,551,217	49

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,755	1,925	$ 100,366	$ 52.14	1
2	Assistant Director of Nursing	3,135	3,459	134,704	38.94	2
3	Registered Nurses	37,547	40,049	1,251,567	31.25	3
4	Licensed Practical Nurses	47,705	50,992	1,385,862	27.18	4
5	CNAs & Orderlies	113,047	120,287	1,353,374	11.25	5
6	CNA Trainees					6
7	Licensed Therapist	38,260	40,797	947,916	23.23	7
8	Rehab/Therapy Aides	13,628	15,225	282,056	18.53	8
9	Activity Director	1,861	2,091	35,971	17.20	9
10	Activity Assistants	9,368	10,038	94,135	9.38	10
11	Social Service Workers	16,647	17,664	274,190	15.52	11
12	Dietician					12
13	Food Service Supervisor	3,846	4,179	75,609	18.09	13
14	Head Cook	5,230	5,709	59,108	10.35	14
15	Cook Helpers/Assistants	21,714	24,340	239,538	9.84	15
16	Dishwashers					16
17	Maintenance Workers	5,622	6,096	91,510	15.01	17
18	Housekeepers	26,796	29,436	284,273	9.66	18
19	Laundry	10,164	11,313	103,088	9.11	19
20	Administrator	3,196	3,487	216,965	62.22	20
21	Assistant Administrator	1,921	2,091	64,925	31.05	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,107	14,826	202,069	13.63	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,864	6,636	100,547	15.15	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	584	656	17,970	27.39	33
34	TOTAL (lines 1 - 33)	382,997	411,296	$ 7,315,743 *	$ 17.79	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 36,076	01-03	35
36	Medical Director	Monthly	10,800	09-03	36
37	Medical Records Consultant	Monthly	4,512	10-03	37
38	Nurse Consultant	Monthly	70,560	10-03	38
39	Pharmacist Consultant	Monthly	13,742	10-03	39
40	Physical Therapy Consultant	50	3,414	10a-03	40
41	Occupational Therapy Consultant	28	1,924	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	628	27,080	10a-03	43
44	Activity Consultant	Monthly	2,244	11-03	44
45	Social Service Consultant	71	3,675	12-03	45
46	Other(specify) Director of Food Serv	Monthly	29,400	01-03	46
47	Specialized Rehab	Monthly	23,520	10a-03	47
48					48
49	TOTAL (lines 35 - 48)	777	$ 226,947		49

C. CONTRACT NURSES

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

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Arleen Manchavez-Siap 1/1/12-8/18/12	Administrator	0.00%	$ 73,017
Mark Solomon (Admin 8/19-12/18)	Executive Director	0.00%	138,183
Colleen Rodney 12/19/12- current	Administrator	0.00%	5,766
Irma Olson	Asst. Admin	0.00%	64,925
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 281,891

B. Administrative - Other

Description	Amount
S.I.R. Mangement - Dir. Of Administrative Services	$ 70,560
S.I.R. Mangement -Ancillary Charges	66,900
S.I.R. Management - Consulting Fee	802,914
TOTAL (agree to Schedule V, line 17, col. 3)	$ 940,374
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg, & Rothblatt	Accounting	$ 20,014
S.I.R. Management	Accounting	36,000
S.I.R. Management	Dir. Of Regulatory Serv.	35,280
S.I.R. Management	Bookkeeping	120,540
Personnel Planners	Unemployment Tax Consult.	2,653
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	3,488
Hamlin & Burton	Liability Management	128
Management & Network Serv.	Software Membership Fee	750
See Supplemetal Schedule		47,430
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 276,914

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 158,750
Unemployment Compensation Insurance	106,489
FICA Taxes	547,270
Employee Health Insurance	248,580
Employee Meals	40,538
Illinois Municipal Retirement Fund (IMRF)*	
Pension Plan	47,723
401k Contribution	13,008
Employee Benefits - Other	13,361
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,175,719

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,992
Advertising: Employee Recruitment	2,696
Health Care Worker Background Check	4,358
(Indicate # of checks performed 435)	
Patient Background Checks	
Advertising	
Dues & Subscriptions	12,595
Licenses and Permits	1,296
Alloc-SIR Management	514
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,451

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	7,302
Alloc-SIR Management	702
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,004

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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 - $8,377**

(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. $ **10,838** 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. $ **538,657**
This amount is to be recorded on line 42 of Schedule V.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **40,538** 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 14**
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 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.