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.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0040410

Facility Name: Elmwood Care

Address: 7733 West Grand Ave (Number) | Elmwood Park (City) | 60707 (Zip Code)

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 4/1/1993

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 01/01/13 to 12/31/13 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: 01/01/13 Ending: 12/31/13

III. STATISTICAL DATA

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

	1 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	89,425	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	89,425	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	57,094	2,420	9,884	69,398	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	57,094	2,420	9,884	69,398	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.60%

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 8,109

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

* 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: 01/01/13 Ending: 12/31/13

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	377,321	53,363	65,157	495,841		495,841	(21,683)	474,158			1
2	Food Purchase		360,769		360,769	(43,274)	317,495	(126)	317,369			2
3	Housekeeping	289,689	87,813		377,502		377,502		377,502			3
4	Laundry	116,353	53,583		169,936		169,936		169,936			4
5	Heat and Other Utilities			242,369	242,369		242,369	(12,437)	229,932			5
6	Maintenance	84,985	53,409	304,218	442,612		442,612	(10,731)	431,881			6
7	Other (specify):*							6,576	6,576			7
8	TOTAL General Services	868,348	608,937	611,744	2,089,029	(43,274)	2,045,755	(38,400)	2,007,354			8
	B. Health Care and Programs											
9	Medical Director			11,550	11,550		11,550	(750)	10,800			9
10	Nursing and Medical Records	4,301,211	778,887	87,713	5,167,811		5,167,811	(138,572)	5,029,239			10
10a	Therapy	281,445		26,202	307,647		307,647	(10,250)	297,397			10a
11	Activities	123,324	4,187	2,244	129,755		129,755		129,755			11
12	Social Services	286,330		420	286,750		286,750		286,750			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							4,166	4,166			15
16	TOTAL Health Care and Programs	4,992,310	783,074	128,129	5,903,513		5,903,513	(145,406)	5,758,107			16
	C. General Administration											
17	Administrative	291,408		925,917	1,217,325		1,217,325	(807,021)	410,304			17
18	Directors Fees											18
19	Professional Services			269,772	269,772	(17,880)	251,892	(177,506)	74,386			19
20	Dues, Fees, Subscriptions & Promotions			63,197	63,197		63,197	(35,957)	27,240			20
21	Clerical & General Office Expenses	190,284	41,927	697,338	929,549		929,549	(486,904)	442,645			21
22	Employee Benefits & Payroll Taxes			1,067,223	1,067,223	43,274	1,110,497		1,110,497			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,387	6,387		6,387	994	7,381			24
25	Other Admin. Staff Transportation			2,944	2,944		2,944	10,094	13,038			25
26	Insurance-Prop.Liab.Malpractice			191,919	191,919		191,919	2,042	193,961			26
27	Other (specify):*							42,536	42,536			27
28	TOTAL General Administration	481,692	41,927	3,224,697	3,748,316	25,394	3,773,710	(1,451,722)	2,321,988			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,342,350	1,433,938	3,964,570	11,740,858	(17,880)	11,722,978	(1,635,529)	10,087,449			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: 01/01/13 Ending: 12/31/13

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			114,068	114,068		114,068	598,827	712,895			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			73,408	73,408		73,408	835,881	909,289			32
33	Real Estate Taxes					17,880	17,880	483,067	500,947			33
34	Rent-Facility & Grounds			1,944,000	1,944,000		1,944,000	(1,944,000)				34
35	Rent-Equipment & Vehicles			7,281	7,281		7,281	6,349	13,630			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,138,757	2,138,757	17,880	2,156,637	(19,876)	2,136,761			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	931,711	635,088	1,044,260	2,611,059		2,611,059		2,611,059			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			514,169	514,169		514,169		514,169			42
43	Other (specify):*	25,191			25,191		25,191	(25,191)				43
44	**TOTAL Special Cost Centers**	956,902	635,088	1,558,429	3,150,419		3,150,419	(25,191)	3,125,228			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,299,252	2,069,026	7,661,756	17,030,034		17,030,034	(1,680,596)	15,349,438			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: 01/01/13 Ending: 12/31/13

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(14,658)	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	167,964	30		9
10	Interest and Other Investment Income	(18,097)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(126)	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	(11,100)	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	(570,120)	21		24
25	Fund Raising, Advertising and Promotional	(14,370)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(197,237)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (657,744)		$	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)	(1,022,852)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,022,852)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,680,596)		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

STATE OF ILLINOIS **Page 5A**

Elmwood Care

ID# 0040410

Report Period Beginning: 01/01/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Purchased Services - VA	$ (36,860)	10	1
2	Collections	(8,977)	19	2
3	Bank Fees	(6,394)	21	3
4	Theft & Damage	(1,277)	21	4
5	Miscellaneous Income	(6,151)	21	5
6	Additional R&M	5,095	06	6
7	Prior Year - Oxygen Expense	(284)	10	7
8	Prior Year - Nursing Equipment Rental	(8,933)	10	8
9	Prior Year - Nursing & Wound Care	(19,542)	10	9
10	Prior Year - Medical Director Consultant	(750)	09	10
11	Prior Year - Bed Rental	(4,079)	10	11
12	Capitalized R&M	(2,512)	06	12
13	Marketing Salary	(25,191)	43	13
14	Non Allowable Professional Fees	(10,000)	19	14
15	Non Allowable Legal Fees	(3,582)	19	15
16	Bldg Co. - Amortization	(20,471)	36	16
17	Bldg Co. - Filing Fees	(700)	21	17
18	Bldg Co. - Office Expense	(898)	21	18
19	Bldg Co. - Professional Fees	(18,038)	19	19
20	COPE Dues	(10,964)	20	20
21	Capitalized R&M - Bldg Co.	(16,729)	06	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**	(197,237)		49

Elmwood Care

ID# 0040410

Report Period Beginning: 01/01/13

Ending: 12/31/13

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

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elmwood Care # 0040410 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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

	Operating Expenses	PAGES 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)	
	A. General Services													
1	Dietary				(21,683)								(21,683)	1
2	Food Purchase	(126)											(126)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(14,658)			2,221								(12,437)	5
6	Maintenance	(14,146)	16,729	(19,103)	5,790								(10,731)	6
7	Other (specify):*			639	5,937								6,576	7
8	**TOTAL General Services**	(28,930)	16,729	(18,464)	(7,735)								(38,400)	8
	B. Health Care and Programs													
9	Medical Director	(750)											(750)	9
10	Nursing and Medical Records	(69,698)		(77,313)	8,439								(138,572)	10
10a	Therapy				(10,250)								(10,250)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			1,300	2,866								4,166	15
16	**TOTAL Health Care and Programs**	(70,448)		(76,013)	1,055								(145,406)	16
	C. General Administration													
17	Administrative			(897,345)	90,324								(807,021)	17
18	Directors Fees													18
19	Professional Services	(40,597)	18,038	(171,288)	16,341								(177,506)	19
20	Fees, Subscriptions & Promotions	(36,434)		477									(35,957)	20
21	Clerical & General Office Expenses	(585,540)	1,598	96,963	75								(486,904)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			994									994	24
25	Other Admin. Staff Transportation			10,094									10,094	25
26	Insurance-Prop.Liab.Malpractice			1,884	158								2,042	26
27	Other (specify):*			24,586	17,950								42,536	27
28	**TOTAL General Administration**	(662,571)	19,636	(933,635)	124,848								(1,451,722)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(761,948)	36,365	(1,028,112)	118,167								(1,635,529)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Elmwood Care **#** 0040410 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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

	Capital Expense 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	167,964	424,162		6,701								598,827	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(18,097)	864,237	(17,234)	6,975								835,881	32
33	Real Estate Taxes		476,637		6,430								483,067	33
34	Rent-Facility & Grounds		(1,944,000)										(1,944,000)	34
35	Rent-Equipment & Vehicles			6,349									6,349	35
36	Other (specify):*	(20,471)	20,471											36
37	**TOTAL Ownership**	129,396	(158,493)	(10,885)	20,106								(19,876)	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):*	(25,191)											(25,191)	43
44	**TOTAL Special Cost Centers**	(25,191)											(25,191)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(657,744)	(122,128)	(1,038,997)	138,273								(1,680,596)	45

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/13 Ending: 12/31/13

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)	
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%	20,471	20,471	2
3	V	30	Depreciation		Elmwood Grand, LLC	100.00%	424,162	424,162	3
4	V	21	Filing Fees		Elmwood Grand, LLC	100.00%	700	700	4
5	V	32	Interest	4,460	Elmwood Grand, LLC	100.00%	868,697	864,237	5
6	V	21	Office Expense		Elmwood Grand, LLC	100.00%	898	898	6
7	V	19	Professional Fees		Elmwood Grand, LLC	100.00%	18,038	18,038	7
8	V	33	Real Estate Taxes	8,363	Elmwood Grand, LLC	100.00%	485,000	476,637	8
9	V	06	Repairs		Elmwood Grand, LLC	100.00%	16,729	16,729	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,956,823			$ 1,834,695	$ * (122,128)	14

*** 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: 01/01/13 Ending: 12/31/13

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%	$ 10,297	$ (19,103)	15
16	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	639	639	16
17	V	10	NURSING	70,560	S.I.R. MANAGEMENT, INC.	100.00%	9,940	(60,620)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	1,300	1,300	18
19	V	19	PROFESSIONAL FEES	191,820	S.I.R. MANAGEMENT, INC.	100.00%	16,235	(175,585)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	477	477	20
21	V	21	CLERICAL & GENERAL	70,560	S.I.R. MANAGEMENT, INC.	100.00%	56,817	(13,743)	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	994	994	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	10,094	10,094	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,884	1,884	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	7,986	7,986	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(17,234)	(17,234)	26
27	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	6,349	6,349	27
28	V								28
29	V	17	ADMINISTRATIVE	925,917	S.I.R. MANAGEMENT, INC.	100.00%	28,572	(897,345)	29
30	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	4,297	4,297	30
31	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	110,706	110,706	31
32	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	16,600	16,600	32
33	V								33
34	V	10	RESPITORY CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	(16,693)	(16,693)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,288,257			$ 249,260	$ * (1,038,997)	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: 01/01/13 Ending: 12/31/13

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%	$ 7,717	$ (21,683)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,015	1,015	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	8,439	8,439	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	1,099	1,099	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	90,324	90,324	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	16,276	16,276	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	17,950	17,950	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	23,520	S.I.R. MANAGEMENT, INC.	100.00%	13,270	(10,250)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,767	1,767	25
26	V								26
27	V	6	MAINTENANCE SALARIES	28,095	S.I.R. MANAGEMENT, INC.	100.00%	33,055	4,961	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	4,922	4,922	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	2,221	2,221	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	829	829	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	65	65	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	75	75	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	158	158	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	6,701	6,701	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	6,975	6,975	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	6,430	6,430	37
38	V								38
39	Total			$ 81,015			$ 219,288	$ * 138,273	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: 01/01/13 Ending: 12/31/13

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	39	Ancillary	$ 15,062	Long Term Care Laboratory, LLC	100.00%	$ 15,062	$	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			$ 15,062			$ 15,062	$ *	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: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	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	LONG TERM CARE LABORATO	ELK GROVE VILLAGE	Laboratory	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%	WESLEY REHABILITATION CENTER	AUBURN, IN				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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

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

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

	1	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	Bryan Barrish	Relative	Administrative	N/A	See Attached	3.37	7.49%	Alloc. Salary	$ 16,849	17-7	1
2	Michael Giannini	Relative	Administrative	N/A	See Attached	2.95	7.38%	Alloc. Salary	14,098	17-7	2
3	Nenita Guzman	Relative	Dietary	N/A	See Attached	4.21	8.42%	Alloc. Salary	7,717	1-7	3
4	Sarah Barrish	Relative	Administrative	N/A	See Attached	3.79	8.42%	Alloc. Salary	8,018	17-7	4
5	Kristen Barrish	Relative	Clerical	N/A	See Attached	4.21	8.42%	Alloc. Salary	4,245	21-7	5
6	Jeff Oravec	Shareholder	Administrative	0.41%	See Attached	3.37	8.43%	Alloc. Salary	11,723	17-7	6
7	Tom Winter	Shareholder	Administrative	1.44%	See Attached	5.05	8.42%	Alloc. Salary	16,849	17-7	7
8	Louise Bergthold	Shareholder	Administrative	4.94%	See Attached	5.05	8.42%	Alloc. Salary	16,849	17-7	8
9	Joey Abramchik	Shareholder	Administrative	2.06%	See Attached	3.37	8.43%	Alloc. Salary	16,276	17-7	9
10	Elka Abramchick	Relative	Clerical	N/A	See Attached	2.70	8.44%	Alloc. Salary	3,689	21-7	10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 116,313		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [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: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	823,778	14	$ 122,226	$ 54,106	69,398	$ 10,297	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	823,778	14	7,581		69,398	639	2
3	10	NURSING	PATIENT DAYS	823,778	14	117,990	117,990	69,398	9,940	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	823,778	14	15,435		69,398	1,300	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	823,778	14	192,718	109,921	69,398	16,235	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	823,778	14	5,665		69,398	477	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	823,778	14	674,435	608,408	69,398	56,817	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	823,778	14	11,805		69,398	994	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	823,778	14	119,815		69,398	10,094	9
10	26	INSURANCE	PATIENT DAYS	823,778	14	22,368		69,398	1,884	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	823,778	14	94,799		69,398	7,986	11
12	32	INTEREST	PATIENT DAYS	823,778	14	(204,568)		69,398	(17,234)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	823,778	14	75,364		69,398	6,349	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	823,778	14	339,156	339,156	69,398	28,572	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	823,778	14	51,011		69,398	4,297	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	823,778	14	1,314,118	1,179,981	69,398	110,706	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	823,778	14	197,046		69,398	16,600	18
19										19
20	10	RESPITORY CONSULTANT	LEASING INCOME	100	2	(18,548)		90	(16,693)	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,138,416	$ 2,409,562		$ 249,260	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	823,778	14	$ 91,605	$ 91,605	69,398	$ 7,717	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	823,778	14	12,049		69,398	1,015	2
3	10	NURSING SALARIES	PATIENT DAYS	823,778	14	100,168	100,168	69,398	8,439	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	823,778	14	13,047		69,398	1,099	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	823,778	14	1,072,182	1,072,182	69,398	90,324	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	823,778	14	193,200		69,398	16,276	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	823,778	14	213,069		69,398	17,950	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	293,544	14	165,622	165,622	23,520	13,270	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	293,544	14	22,047		23,520	1,767	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	378,109	14	444,871	444,871	28,095	33,055	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	378,109	14	66,242		28,095	4,922	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	14	26,365		1,085	2,221	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	14	9,845		1,085	829	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	14	768		1,085	65	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	14	896		1,085	75	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	14	1,870		1,085	158	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	14	79,536		1,085	6,701	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	14	82,793		1,085	6,975	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	14	76,319		1,085	6,430	23
24										24
25	TOTALS					$ 2,672,494	$ 1,874,447		$ 219,288	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Long Term Care Laboratory, LLC
Street Address: 2458 Elmhurst Road
City / State / Zip Code: Elk Grove Village, IL 60007
Phone Number: (630)422-7800
Fax Number: (847)422-1360

	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	39	Ancillary	Direct Allocation			$	$		$ 15,062	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					$	$		$ 15,062	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
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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: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/13 Ending: 12/31/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	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	First Merit Bank		X	Mortgage			$	$ 14,900,000			$ 868,697	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Lake Forest Bank		X	Line of Credit				2,270,000			73,408	6
7	SIR Management	X		Note Payable				1,000,000				7
8	See Supplemental Schedule										6,975	8
9	TOTAL Facility Related						$	$ 18,170,000			$ 949,080	9
	B. Non-Facility Related*											
10	Interest Income		X								(18,097)	10
11	Interest Income - Bldg Co.		X								(4,460)	11
12	Allocated - S.I.R. Management										(17,234)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (39,791)	14
15	TOTALS (line 9+line14)						$	$ 18,170,000			$ 909,289	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None 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: 01/01/13 Ending: 12/31/13

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocated - S.I.R. Management						$	$			$ 6,975	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										6,975	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:** 01/01/13 **Ending:** 12/31/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 470,000	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.)		$ 468,067	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,933)	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 485,000	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.)**		$ 17,880	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 500,947	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	470,084	8
	2009	521,243	9
	2010	444,758	10
	2011	447,084	11
	2012	461,637	12

2013 Accrual = $461,637 x 1.05 = $485,000 (Rounded)

Allocated from S.I.R. Management: $6,430

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Elmwood Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040410

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2012 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2012.

	(A) 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	$ 126,602.47	$ 126,602.47
2.	12-25-323-004-0000	Long Term Care Property	$ 126,478.16	$ 126,478.16
3.	12-25-323-005-0000	Long Term Care Property	$ 197,994.34	$ 197,994.34
4.	12-25-324-001-0000	Long Term Care Property	$ 5,710.54	$ 5,710.54
5.	12-25-324-002-0000	Long Term Care Property	$ 4,851.89	$ 4,851.89
6.	See Attaached	Allocation from S.I.R. Management	$ 106,516.99	$ 7,027.72
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 568,154.39	$ 468,665.12

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

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

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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Elmwood Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040410

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 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	$ 5,761,749	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	129,203		20	4,602	4,602	129,189	9
10	Various			1994	49,738		20	2,486	2,486	48,601	10
11	Various			1995	167,102		20	8,355	8,355	154,865	11
12	Various			1996	136,090		20	6,805	6,805	118,142	12
13	Various			1997	16,180		20	809	809	13,386	13
14	Various			1998	158,155		20	6,538	6,538	127,999	14
15	Various			1999	121,088		20	6,054	6,054	87,985	15
16	Various			2000	67,583		20	3,379	3,379	45,490	16
17	Various			2001	107,654		20	5,383	5,383	67,809	17
18	Various			2002	113,214		20	943	943	111,776	18
19	Various			2003	145,109		20	7,717	7,717	81,480	19
20	Various			2004	124,757		20	5,954	5,954	59,384	20
21	Various			2005	84,119		20	4,706	4,706	41,551	21
22	Various			2006	127,687		20	6,917	6,917	51,130	22
23	Various			2007	117,180		20	6,773	6,773	44,732	23
24	Various			2008	56,513		20	2,826	2,826	15,683	24
25	Various			2009	123,292		20	7,159	7,159	32,091	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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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)		2,737,586	105,281		136,879	31,598	762,805	67
68	Related Party Allocations (Pages 12H & 12I)		166,380	4,244		5,961	1,717	82,654	68
69	Financial Statement Depreciation			114,068			(114,068)		69
70	TOTAL (lines 4 thru 69)		$ 15,168,139	$ 480,753		$ 527,947	$ 47,194	$ 7,838,501	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: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 15,168,139	$ 480,753		$ 527,947	$ 47,194	$ 7,838,501	1
2	Painting	2010	6,150		20	308	308	1,230	2
3	Ventilator Alarm	2010	19,250		20	963	963	3,609	3
4	Fence And Gate	2010	3,374		20	169	169	633	4
5	Dialysis Renovation	2010	149,735		20	7,487	7,487	26,828	5
6	Fire Stopping	2010	7,000		20	350	350	1,167	6
7	Office Carpet	2010	3,496		20	175	175	670	7
8	Cubicle Curtains	2010	3,369		20	168	168	674	8
9	Lobby Drapes	2010	7,133		20	357	357	1,367	9
10	Alarm System	2010	3,155		20	158	158	605	10
11	Boiler Work	2010	14,408		20	720	720	2,762	11
12	Custom Woodwork	2010	19,780		20	989	989	3,626	12
13	Trash Chute	2010	2,752		20	138	138	505	13
14	Walk-In Cooler Repair	2010	4,841		20	242	242	948	14
15	Replace Wallpaper	2010	2,600		20	130	130	498	15
16	Start Up Chiller	2010	4,547		20	227	227	834	16
17	Replace Locks	2010	3,181		20	159	159	610	17
18	Ventilators	2011	9,013		20	901	901	2,704	18
19	Window Screen Repairs	2011	2,886		20	144	144	325	19
20	Hallway Cabinetry	2012	2,880		20	144	144	276	20
21	Sprinkler Heads	2012	3,430		20	172	172	314	21
22	Sewage Pump	2012	4,395		20	220	220	421	22
23	Security Camera System	2012	9,153		20	458	458	877	23
24	Therapy Room Cabinetry	2012	9,800		20	490	490	817	24
25	Storage Room Cabinetry	2012	6,000		20	300	300	425	25
26	Fire Duct Detectors	2012	4,646		20	232	232	290	26
27	Boiler Work	2012	6,382		20	319	319	372	27
28	Install Handrails, Corner Guards And Crashrails	2012	3,248		20	162	162	189	28
29	Ffi-Fire Stop System	2013	5,990		20	225	225	225	29
30	Elevator Upgrades	2013	17,081		20	427	427	427	30
31	Hvac Repairs	2013	2,512		20	126	126	126	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 15,510,326	$ 480,753		$ 545,005	$ 64,252	$ 7,892,854	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: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 15,510,326	$ 480,753		$ 545,005	$ 64,252	$ 7,892,854	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 15,510,326	$ 480,753		$ 545,005	$ 64,252	$ 7,892,854	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: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 15,510,326	$ 480,753		$ 545,005	$ 64,252	$ 7,892,854	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
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 15,510,326	$ 480,753		$ 545,005	$ 64,252	$ 7,892,854	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: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 15,510,326	$ 480,753		$ 545,005	$ 64,252	$ 7,892,854	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
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17									17
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19									19
20									20
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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)		$ 15,510,326	$ 480,753		$ 545,005	$ 64,252	$ 7,892,854	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: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	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	468,000	9
10	Painting	2008	130,000	13,000	20	6,500	(6,500)	39,000	10
11	Elevator Cab	2008	43,612	2,181	20	2,181	(0)	13,084	11
12	Hand Rails	2008	15,105	1,511	20	755	(756)	4,532	12
13	Nurse Station	2008	112,920	5,646	20	5,646		33,876	13
14	Side Entry Hub	2008	8,245	825	20	412	(413)	2,474	14
15	Nurses Stations	2009	37,640	1,882	20	1,882		9,410	15
16	Window Treatement	2009	6,775	677	20	339	(338)	1,694	16
17	1st Floor Tile	2009	126,810	6,341	20	6,341	(1)	31,703	17
18	Resident Bathroom/Dayroom - Ceiling, Fixtures, Tiles, Paint	2009	202,085	10,104	20	10,104	0	50,521	18
19	Wiring	2009	10,034		20	502	502	2,509	19
20	Windows	2009	3,200	320	20	160	(160)	800	20
21	Lower Level Mall-Ceiling, Plumbing, Doors, Paint	2009	201,263	10,063	20	10,063	0	50,316	21
22	Painting	2009	15,000	1,500	20	750	(750)	3,750	22
23	Lower Level Mall-Drawings for Construction Permit	2009	9,000	450	20	450		2,250	23
24	2nd Floor Work	2009	23,400	1,170	20	1,170		5,850	24
25	2nd Floor Ceiling	2009	16,070	804	20	804	(1)	4,018	25
26	Sprinkler System Renovation	2009	11,017	551	20	551	(0)	2,754	26
27	Chair rail in dining Room	2009	11,312	566	20	566	(0)	2,828	27
28	Handrails - Floors 2,3,4	2009	44,652	2,233	20	2,233	(0)	11,163	28
29	Wallbase - Floors 2,3,4	2009	15,324	766	20	766	0	3,831	29
30	Tuckpointing	2011	61,030	1,526	20	3,052	1,526	9,155	30
31	Generator Project	2011	56,363	2,818	20	2,818	0	8,454	31
32	Replace, Resurface, & Restripe Asphalt Pavement	2013	13,500		20	675	675	675	32
33	Smoke Detectors	2013	3,229		20	161	161	161	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: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		$	$		$	$	$	1
2									2
3	Additional R&M			1,347			(1,347)		3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		$ 2,737,586	$ 105,281		$ 136,879	$ 31,598	$ 762,805	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: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Alloc. - S.I.R. Management	2009	21,061		20	540	540	2,183	3
4	Alloc. - S.I.R. Properties - S.I.R. Management	1993	38,135	1,211	20	1,090	(121)	22,336	4
5									5
6									6
7									7
8	Leasehold Information								8
9	Alloc. - S.I.R. Management	1993	9,668	269	20	82	(187)	9,668	9
10	Alloc. - S.I.R. Management	1994	30		20			30	10
11	Alloc. - S.I.R. Management	1995	221		20	11	11	203	11
12	Alloc. - S.I.R. Management	1997	14,856	333	20	724	391	12,434	12
13	Alloc. - S.I.R. Management	1999	1,168		20	58	58	832	13
14	Alloc. - S.I.R. Management	1999	13,707		20			13,707	14
15	Alloc. - S.I.R. Management	2000	1,379		20	69	69	934	15
16	Alloc. - S.I.R. Management	2007	4,431	302	20	222	(80)	1,372	16
17	Alloc. - S.I.R. Management	2008	12,212	1,167	20	770	(397)	4,499	17
18	Alloc. - S.I.R. Management	2009	30,346	278	20	1,517	1,239	6,440	18
19	Alloc. - S.I.R. Management	2011	751	75	20	75		181	19
20	Alloc. - S.I.R. Management	2012	2,403	120	20	120		170	20
21									21
22	Alloc. - S.I.R. Properties - S.I.R. Management	2012	2,336	322	20	16	(306)	19	22
23	Alloc. - S.I.R. Properties - S.I.R. Management	2010	2,301		20	115	115	384	23
24	Alloc. - S.I.R. Properties - S.I.R. Management	2009	2,290	102	20	114	12	550	24
25	Alloc. - S.I.R. Properties - S.I.R. Management	2007	668	53	20	33	(20)	234	25
26	Alloc. - S.I.R. Properties - S.I.R. Management	2002	151		20	8	8	87	26
27	Alloc. - S.I.R. Properties - S.I.R. Management	1999	4,832		20	242	242	3,503	27
28	Alloc. - S.I.R. Properties - S.I.R. Management	1998	2,309		20	115	115	1,790	28
29	Alloc. - S.I.R. Properties - S.I.R. Management	1997	144		20	7	7	126	29
30	Alloc. - S.I.R. Properties - S.I.R. Management	1994	363	9	20	18	9	354	30
31	Alloc. - S.I.R. Properties - S.I.R. Management	1993	618	3	20	15	12	618	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: 01/01/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	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
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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)		$ 166,380	$ 4,244		$ 5,961	$ 1,717	$ 82,654	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: 01/01/13 Ending: 12/31/13

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	$ 2,625,399	$ 63,870	$ 164,151	$ 100,281	10	$ 1,123,334	71
72	Current Year Purchases	119,256		3,360	3,360	10	75,254	72
73	Fully Depreciated Assets	493,536		26	26	10	493,536	73
74								74
75	TOTALS	$ 3,238,191	$ 63,870	$ 167,538	$ 103,668		$ 1,692,124	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 S.I.R. Manageme	2011	$ 2,961	$ 310	$ 354	$ 44	5	$ 1,390	76
77										77
78										78
79										79
80	TOTALS			$ 2,961	$ 310	$ 354	$ 44		$ 1,390	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)	$ 19,476,469	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 544,933	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 712,897	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 167,964	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 9,586,368	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/13 Ending: 12/31/13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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.	/2014	$
13.	/2015	$
14.	/2016	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 13,630 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: 01/01/13 Ending: 12/31/13

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 # 0040410 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 205,102	$		$ 205,102	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			256,150			256,150	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			357,211			357,211	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				284,269		284,269	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			931,711		225,797	350,819		1,508,327	13
14	TOTAL			$ 931,711		$ 1,044,260	$ 635,088		$ 2,611,059	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/13 Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 31,148	$ 1,111,841	1
2	Cash-Patient Deposits	50,116	50,116	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,397,133	3,397,133	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	91,508	91,508	6
7	Other Prepaid Expenses	498	498	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,570,403	$ 4,651,096	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	1,077,543	3,813,100	15
16	Equipment, at Historical Cost	2,749,292	4,105,402	16
17	Accumulated Depreciation (book methods)	(2,454,178)	(9,428,229)	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	130,000	2,087,011	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,502,657	$ 11,724,784	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,073,060	$ 16,375,880	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 890,115	$ 1,001,162	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	50,116	50,116	28
29	Short-Term Notes Payable	2,270,000	2,270,000	29
30	Accrued Salaries Payable	505,316	505,316	30
31	Accrued Taxes Payable (excluding real estate taxes)	94,271	94,271	31
32	Accrued Real Estate Taxes(Sch.IX-B)		485,000	32
33	Accrued Interest Payable		35,740	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	93,138	93,138	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,902,956	$ 4,534,743	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				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)**	$ 3,902,956	$ 20,434,743	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,170,104	$ (4,058,863)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,073,060	$ 16,375,880	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/13 Ending: 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 934,974	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 934,974	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	769,730	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	(534,600)	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)**	$ 235,130	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)**	$ 1,170,104	24	*

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	$ 16,295,048	1
2	Discounts and Allowances for all Levels	(2,622,277)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,672,771	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,975,607	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,975,607	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	271,123	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,587	19
20	Radiology and X-Ray	1,075	20
21	Other Medical Services	321,755	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 621,540	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	18,097	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 18,097	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	511,749	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 511,749	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,799,764	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,089,029	31
32	Health Care	5,903,513	32
33	General Administration	3,748,316	33
	B. Capital Expense		
34	Ownership	2,138,757	34
	C. Ancillary Expense		
35	Special Cost Centers	2,636,250	35
36	Provider Participation Fee	514,169	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,030,034	40
41	**Income before Income Taxes (line 30 minus line 40)****	769,730	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 769,730	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 10,860,241	44
45	Private Pay - Net Inpatient Revenue	525,258	45
46	Medicare - Net Inpatient Revenue	1,505,428	46
47	Other-(specify) VA	238,375	47
48	Other-(specify) Hospice/HMO/Ins	543,469	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 13,672,771	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: 01/01/13 Ending: 12/31/13

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,035	2,188	$ 134,134	$ 61.30	1
2	Assistant Director of Nursing	1,727	2,176	84,676	38.91	2
3	Registered Nurses	32,118	34,841	1,048,286	30.09	3
4	Licensed Practical Nurses	51,474	55,312	1,499,834	27.12	4
5	CNAs & Orderlies	113,931	121,460	1,314,340	10.82	5
6	CNA Trainees					6
7	Licensed Therapist	36,994	39,931	931,711	23.33	7
8	Rehab/Therapy Aides	13,299	14,894	281,445	18.90	8
9	Activity Director	1,754	2,672	46,313	17.33	9
10	Activity Assistants	7,701	8,254	77,011	9.33	10
11	Social Service Workers	15,799	15,978	286,330	17.92	11
12	Dietician					12
13	Food Service Supervisor	3,571	3,957	73,639	18.61	13
14	Head Cook	5,337	5,986	64,498	10.77	14
15	Cook Helpers/Assistants	21,245	23,353	239,184	10.24	15
16	Dishwashers					16
17	Maintenance Workers	5,805	6,154	84,985	13.81	17
18	Housekeepers	26,184	28,704	289,689	10.09	18
19	Laundry	10,969	11,864	116,353	9.81	19
20	Administrator	3,258	3,553	229,938	64.72	20
21	Assistant Administrator	1,557	1,806	61,470	34.04	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,030	18,562	190,284	10.25	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	8,883	9,987	219,941	22.02	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,144	1,160	25,191	21.72	33
34	TOTAL (lines 1 - 33)	380,815	412,792	$ 7,299,252 *	$ 17.68	34

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	$ 35,757	01-03	35
36	Medical Director	Monthly	11,550	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	12,641	10-03	39
40	Physical Therapy Consultant	9	638	10a-03	40
41	Occupational Therapy Consultant	7	491	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	36	1,553	10a-03	43
44	Activity Consultant	Monthly	2,244	11-03	44
45	Social Service Consultant	8	420	12-03	45
46	Other(specify) Dir of Food Service	Monthly	29,400	01-03	46
47	Specialized Rehab	Monthly	23,520	10a-03	47
48					48
49	TOTAL (lines 35 - 48)	60	$ 193,286		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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/13 Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mark Solomon	Administrator	0	$ 90,374
Colleen Swanson	Administrator	0	139,564
Barbara Dabrowski	Asst. Admin	0	51,623
Irma Olson	Asst. Admin	0	9,847
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 291,408

B. Administrative - Other

Description	Amount
S.I.R. Mangement - Dir. Of Administrative Services	$ 70,560
S.I.R. Mangement -Ancillary Charges	58,800
S.I.R. Management - Consulting Fee	796,557
TOTAL (agree to Schedule V, line 17, col. 3)	$ 925,917
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg, & Rothblatt	Accounting	$ 15,785
Plante & Moran	Accounting	5,325
Personnel Planners, Inc.	Unemployment Consult	3,171
S.I.R. Management	Accounting	36,000
S.I.R. Management	Dir. Of Regulatory Serv.	35,280
S.I.R. Management	Bookkeeping	120,540
Pinnacle Consulting	Customer Satisfaction	3,101
E-Health Data Solutions	Data Processing	3,300
Achieve Accreditation	Credentialing Services	11,723
Legat Architect	Architect	6,573
Honkemp Kruegar	Tax Credit Program	2,384
See Supplemental Schedule		26,592
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 269,774

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 121,426
Unemployment Compensation Insurance	107,473
FICA Taxes	549,550
Employee Health Insurance	242,008
Employee Meals	43,274
Illinois Municipal Retirement Fund (IMRF)*	
Pension Plan	17,490
401K Contribution	11,891
Other Employee Benefits	17,385
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,110,497

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	1,000
Health Care Worker Background Check	
(Indicate # of checks performed 423)	4,225
Patient Background Checks	
Dues & Subscriptions	15,538
Licenses & Permits	4,008
Allocated from S.I.R. Management	477
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,240

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,387
Allocated from S.I.R. Management	994
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,381

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council: $19,969**

(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. $ **13,490** Line **10-02**

(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. $ **514,169**
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. $ **43,274** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **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? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.