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.

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

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 01/01/14 to 12/31/14 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) 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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	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	41,930	1,815	23,809	67,554	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,930	1,815	23,809	67,554	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.54%

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 6,336

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

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	377,109	128,505	65,551	571,165		571,165	(22,778)	548,387			1
2	Food Purchase		365,234		365,234	(44,983)	320,251	(98)	320,153			2
3	Housekeeping	284,129	102,392		386,521		386,521		386,521			3
4	Laundry	122,073	57,724		179,797		179,797		179,797			4
5	Heat and Other Utilities			320,901	320,901		320,901	(12,182)	308,719			5
6	Maintenance	92,336	85,478	367,542	545,356		545,356	13,220	558,576			6
7	Other (specify):*							22,445	22,445			7
8	**TOTAL General Services**	875,647	739,333	753,994	2,368,974	(44,983)	2,323,991	607	2,324,598			8
	B. Health Care and Programs											
9	Medical Director			28,300	28,300		28,300		28,300			9
10	Nursing and Medical Records	4,446,746	640,932	89,448	5,177,126		5,177,126	(87,376)	5,089,750			10
10a	Therapy	293,355		32,131	325,486		325,486	(12,082)	313,404			10a
11	Activities	125,281	2,806	2,401	130,488		130,488		130,488			11
12	Social Services	255,780			255,780		255,780		255,780			12
13	CNA Training											13
14	Program Transportation			5,710	5,710		5,710		5,710			14
15	Other (specify):*							7,050	7,050			15
16	**TOTAL Health Care and Programs**	5,121,162	643,738	157,990	5,922,890		5,922,890	(92,408)	5,830,482			16
	C. General Administration											
17	Administrative	206,201		952,590	1,158,791		1,158,791	(829,449)	329,342			17
18	Directors Fees											18
19	Professional Services			252,892	252,892	(8,813)	244,079	(153,511)	90,568			19
20	Dues, Fees, Subscriptions & Promotions			76,323	76,323		76,323	(34,830)	41,493			20
21	Clerical & General Office Expenses	210,427	49,307	596,041	855,775		855,775	(382,609)	473,166			21
22	Employee Benefits & Payroll Taxes			1,114,460	1,114,460	44,983	1,159,443		1,159,443			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,957	8,957		8,957	616	9,573			24
25	Other Admin. Staff Transportation			2,947	2,947		2,947	11,550	14,497			25
26	Insurance-Prop.Liab.Malpractice			257,188	257,188		257,188	3,877	261,065			26
27	Other (specify):*							47,583	47,583			27
28	**TOTAL General Administration**	416,628	49,307	3,261,398	3,727,333	36,170	3,763,503	(1,336,774)	2,426,729			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,413,437	1,432,378	4,173,382	12,019,197	(8,813)	12,010,384	(1,428,574)	10,581,810			29

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

Facility Name & ID Number Elmwood Care #0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			120,176	120,176		120,176	668,801	788,977			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			99,990	99,990		99,990	840,166	940,156			32
33	Real Estate Taxes					8,813	8,813	622,599	631,412			33
34	Rent-Facility & Grounds			1,944,000	1,944,000		1,944,000	(1,944,000)				34
35	Rent-Equipment & Vehicles			7,052	7,052		7,052	7,364	14,416			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,171,218	2,171,218	8,813	2,180,031	194,930	2,374,960			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	964,526	729,744	915,170	2,609,440		2,609,440		2,609,440			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			520,905	520,905		520,905		520,905			42
43	Other (specify):*	75,343			75,343		75,343	(75,343)				43
44	**TOTAL Special Cost Centers**	1,039,869	729,744	1,436,075	3,205,688		3,205,688	(75,343)	3,130,345			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,453,306	2,162,122	7,780,675	17,396,103	0	17,396,103	(1,308,988)	16,087,115			45

THE TOTAL FOR COLUMN 5 MUST BE ZERO,PLEASE CORRECT

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 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	(15,412)	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	234,190	30		9
10	Interest and Other Investment Income	(2,000)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(98)	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	(11,560)	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	(449,550)	21		24
25	Fund Raising, Advertising and Promotional	(19,900)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(10,500)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(249,844)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (524,675)		$	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)	(784,313)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (784,313)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,308,988)		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

STATE OF ILLINOIS **Page 5A**

Elmwood Care

ID# 0040410

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Purchased Services - VA	$ (49,814)	10	1
2	Legal Fees - Collections	(10,257)	21	2
3	Bank Fees	(6,380)	21	3
4	Theft & Damage	(2,435)	21	4
5	Miscellaneous Income	(6,100)	21	5
6	Bldg Co. - Amortization	(20,471)	36	6
7	Bldg Co. - Contributions	(2,500)	20	7
8	Bldg Co. - Filing Fees	(500)	21	8
9	Bldg Co. - Office Expense	(1,337)	21	9
10	Bldg Co. - Professional Fees	(23,702)	19	10
11	Additional R&M	4,728	06	11
12	Capitalized R&M	(16,536)	06	12
13	Marketing Salary	(75,343)	43	13
14	PPA - Nursing Equipment Rental	(4,707)	10	14
15	Non Allowable Legal Fees	(341)	19	15
16	PAC Dues	(6,590)	20	16
17	Annual Report	(100)	20	17
18	2015 Seminar	(315)	24	18
19	Non-Care Real Estate Taxes	(2,604)	33	19
20	Bldg Co. - Capitalized R&M	(24,540)	06	20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(249,844)		49

Elmwood Care

ID# 0040410

Report Period Beginning: 01/01/14

Ending: 12/31/14

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

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elmwood Care # 0040410 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Operating Expenses	PAGES 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				(22,778)								(22,778)	1
2	Food Purchase	(98)											(98)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(15,412)	966		2,264								(12,182)	5
6	Maintenance	(36,348)	24,540	(16,767)	41,795								13,220	6
7	Other (specify):*			793	21,652								22,445	7
8	**TOTAL General Services**	(51,858)	25,506	(15,974)	42,933								607	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(54,522)		(42,017)	9,163								(87,376)	10
10a	Therapy				(12,082)								(12,082)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			4,036	3,014								7,050	15
16	**TOTAL Health Care and Programs**	(54,522)		(37,981)	95								(92,408)	16
	C. General Administration													
17	Administrative			(922,136)	92,687								(829,449)	17
18	Directors Fees													18
19	Professional Services	(24,043)	23,702	(171,753)	18,583								(153,511)	19
20	Fees, Subscriptions & Promotions	(40,650)	2,500	3,320									(34,830)	20
21	Clerical & General Office Expenses	(487,058)	1,837	102,530	82								(382,609)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(315)		931									616	24
25	Other Admin. Staff Transportation			11,550									11,550	25
26	Insurance-Prop.Liab.Malpractice		1,304	2,411	162								3,877	26
27	Other (specify):*			28,444	19,139								47,583	27
28	**TOTAL General Administration**	(552,067)	29,343	(944,703)	130,653								(1,336,774)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(658,446)	54,849	(998,658)	173,681								(1,428,574)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Elmwood Care **#** 0040410 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Capital Expense 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	234,190	428,020		6,591								668,801	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,000)	857,966	(22,969)	7,169								840,166	32
33	Real Estate Taxes	(2,604)	616,562		8,641								622,599	33
34	Rent-Facility & Grounds		(1,944,000)										(1,944,000)	34
35	Rent-Equipment & Vehicles			7,364									7,364	35
36	Other (specify):*	(20,471)	20,471											36
37	**TOTAL Ownership**	209,115	(20,981)	(15,605)	22,401								194,930	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):*	(75,343)											(75,343)	43
44	**TOTAL Special Cost Centers**	(75,343)											(75,343)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(524,675)	33,868	(1,014,263)	196,082								(1,308,988)	45

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 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	$ 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	20	Contributions		Elmwood Grand, LLC	100.00%	2,500	2,500	3
4	V	30	Depreciation		Elmwood Grand, LLC	100.00%	428,020	428,020	4
5	V	21	Filing Fees		Elmwood Grand, LLC	100.00%	500	500	5
6	V	26	Insurance		Elmwood Grand, LLC	100.00%	1,304	1,304	6
7	V	32	Interest	4,436	Elmwood Grand, LLC	100.00%	862,402	857,966	7
8	V	21	Office Expense		Elmwood Grand, LLC	100.00%	1,337	1,337	8
9	V	19	Professional Fees		Elmwood Grand, LLC	100.00%	23,702	23,702	9
10	V	33	Real Estate Taxes		Elmwood Grand, LLC	100.00%	616,562	616,562	10
11	V	06	Repairs		Elmwood Grand, LLC	100.00%	24,540	24,540	11
12	V	05	Utilities		Elmwood Grand, LLC	100.00%	966	966	12
13	V								13
14	Total			$ 1,948,436			$ 1,982,304	$ * 33,868	14

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS AND MAINT.	$ 29,400	S.I.R. MANAGEMENT, INC.	100.00%	$ 12,633	$ (16,767)	15
16	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	793	793	16
17	V	10	NURSING	70,560	S.I.R. MANAGEMENT, INC.	100.00%	28,543	(42,017)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	4,036	4,036	18
19	V	19	PROFESSIONAL FEES	191,820	S.I.R. MANAGEMENT, INC.	100.00%	11,966	(179,854)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	3,320	3,320	20
21	V	21	CLERICAL & GENERAL	70,560	S.I.R. MANAGEMENT, INC.	100.00%	53,165	(17,395)	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	931	931	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	11,550	11,550	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	2,411	2,411	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	8,385	8,385	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(22,969)	(22,969)	26
27	V	35	AUTO RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	6,126	6,126	27
28	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	1,238	1,238	28
29	V								29
30	V	17	ADMINISTRATIVE	952,590	S.I.R. MANAGEMENT, INC.	100.00%	30,454	(922,136)	30
31	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	8,101	8,101	31
32	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	119,925	119,925	32
33	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	20,059	20,059	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,314,930			$ 300,667	$ * (1,014,263)	39

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 29,400	S.I.R. MANAGEMENT, INC.	100.00%	$ 6,622	$ (22,778)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	977	977	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	9,163	9,163	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	1,306	1,306	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	92,687	92,687	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	17,704	17,704	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	19,139	19,139	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	23,520	S.I.R. MANAGEMENT, INC.	100.00%	11,438	(12,082)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,708	1,708	25
26	V								26
27	V	6	MAINTENANCE SALARIES	92,173	S.I.R. MANAGEMENT, INC.	100.00%	132,190	40,017	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	20,675	20,675	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	2,264	2,264	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	1,778	1,778	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	879	879	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	82	82	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	162	162	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	6,591	6,591	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	7,169	7,169	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	8,641	8,641	37
38	V								38
39	Total			$ 145,093			$ 341,175	$ * 196,082	39

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Ancillary	$ 33,741	Long Term Care Laboratory, LLC	100.00%	$ 33,741	$	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			$ 33,741			$ 33,741	$ *	39

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	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	OAKTON ARMS	DES PLAINES	Assisted Living	5
6	GALE ROTHNER	9.465%	GREENWOOD CARE, INC.	EVANSTON				6
7	HARVEY SCOTT	0.823%	NEIGHBORS REHABILITATION CENTER,LLC	BYRON				7
8	JEFF ORAVEC	0.412%	REGENCY REHABILITATION CENTER,LLC	NILES				8
9	JOEY ABRAMCHIK	2.058%	ROCK ISLAND NURSING & REHAB CENTER,LLC	ROCK ISLAND				9
10	JULIANA R. BARRISH TRUST DTD 1/26/93	14.249%	WILSON CARE, INC.	CHICAGO				10
11	KATHRYN VALES TRUST	2.881%	WESLEY REHABILITATION CENTER	AUBURN, IN				11
12	KIMBERLY RICHMAN TRUST	2.881%	OAKTON PAVILION	DES PLAINES				12
13	LORI BARRISH	2.058%						13
14	LOUISE BERGTHOLD	4.938%						14
15	MELISSA ROTHNER TRUST	2.881%						15
16	MICHAEL R GIANNINI TRUST DTD 3/13/00	11.574%						16
17	RACHEL ROTHNER TRUST	2.881%						17
18	THOMAS WINTER	1.440%						18
19	WILLIAM ROTHNER TRUST	2.881%						19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bryan Barrish	Relative	Administrative	0	See Attached	3.60	8.00%	Alloc. Salary	$ 17,978	17-7	1
2	Michael Giannini	Relative	Administrative	0	See Attached	3.15	7.88%	Alloc. Salary	15,005	17-7	2
3	Nenita Guzman	Relative	Dietary	0	See Attached	4.49	8.98%	Alloc. Salary	6,622	1-7	3
4	Sarah Barrish	Relative	Administrative	0	See Attached	4.04	8.98%	Alloc. Salary	10,936	17-7	4
5	Kristen Barrish	Relative	Clerical	0	See Attached	4.49	8.98%	Alloc. Salary	8,292	21-7	5
6	Jeff Oravec	Shareholder	Administrative	0.41%	See Attached	3.60	9.00%	Alloc. Salary	12,477	17-7	6
7	Tom Winter	Shareholder	Administrative	1.44%	See Attached	5.39	8.98%	Alloc. Salary	17,978	17-7	7
8	Louise Bergthold	Shareholder	Administrative	4.94%	See Attached	5.39	8.98%	Alloc. Salary	17,978	17-7	8
9	Joey Abramchik	Shareholder	Administrative	2.06%	See Attached	3.60	9.00%	Alloc. Salary	17,704	17-7	9
10	See Supplemental Schedule								7,202		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	$ 132,172		13

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

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: 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	751,530	16	$ 140,542	$ 58,090	67,554	$ 12,633	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	751,530	16	8,819		67,554	793	2
3	10	NURSING	PATIENT DAYS	751,530	16	317,539	317,539	67,554	28,543	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	751,530	16	44,898		67,554	4,036	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	751,530	16	133,120	89,849	67,554	11,966	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	751,530	16	36,940		67,554	3,320	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	751,530	16	591,459	531,411	67,554	53,165	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	751,530	16	10,362		67,554	931	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	751,530	16	128,491		67,554	11,550	9
10	26	INSURANCE	PATIENT DAYS	751,530	16	26,818		67,554	2,411	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	751,530	16	93,282		67,554	8,385	11
12	32	INTEREST	PATIENT DAYS	751,530	16	(255,531)		67,554	(22,969)	12
13	35	AUTO RENTAL	PATIENT DAYS	751,530	16	68,150		67,554	6,126	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	751,530	16	13,772		67,554	1,238	14
15										15
16	17	ADMINISTRATIVE	PATIENT DAYS	751,530	16	338,802	338,802	67,554	30,454	16
17	19	PROFESSIONAL FEES	PATIENT DAYS	751,530	16	90,119		67,554	8,101	17
18	21	CLERICAL & GENERAL	PATIENT DAYS	751,530	16	1,334,152	1,203,304	67,554	119,925	18
19	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	751,530	16	223,152		67,554	20,059	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,344,886	$ 2,538,995		$ 300,667	25

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: 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	751,530	16	$ 73,669	$ 73,669	67,554	$ 6,622	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	751,530	16	10,866		67,554	977	2
3	10	NURSING SALARIES	PATIENT DAYS	751,530	16	101,941	101,941	67,554	9,163	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	751,530	16	14,528		67,554	1,306	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	751,530	16	1,031,137	1,031,137	67,554	92,687	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	751,530	16	196,950		67,554	17,704	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	751,530	16	212,914		67,554	19,139	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	274,680	15	133,582	133,582	23,520	11,438	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	274,680	15	19,951		23,520	1,708	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	395,144	15	566,698	566,698	92,173	132,190	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	395,144	15	88,633		92,173	20,675	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,880	15	25,179		1,158	2,264	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,880	15	19,781		1,158	1,778	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,880	15	9,777		1,158	879	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,880	15	907		1,158	82	19
20	26	INSURANCE	ALLOCATED SQ FT	12,880	15	1,804		1,158	162	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,880	15	73,312		1,158	6,591	21
22	32	INTEREST	ALLOCATED SQ FT	12,880	15	79,739		1,158	7,169	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,880	15	96,114		1,158	8,641	23
24										24
25	TOTALS					$ 2,757,482	$ 1,907,027		$ 341,175	25

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: 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			$	$		$ 33,741	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					$	$		$ 33,741	25

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	First Merit Bank		X	Mortgage			$	$ 14,900,000			$ 862,402	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Lake Forest Bank		X	Line of Credit				2,550,000			99,990	6
7	SIR Management	X		Note Payable				1,000,000				7
8	See Supplemental Schedule										7,169	8
9	TOTAL Facility Related						$	$ 18,450,000			$ 969,561	9
	B. Non-Facility Related*											
10	Interest Income		X								(2,000)	10
11	Interest Income - Bldg Co.		X								(4,436)	11
12	Allocated from SIR Managemer	X									(22,969)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (29,405)	14
15	TOTALS (line 9+line14)						$	$ 18,450,000			$ 940,156	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.)**

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

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocated from SIR Managemer	X					$	$			$ 7,169	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										7,169	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: 01/01/14 Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 485,000	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.)		$ 543,599	2
3. Under or (over) accrual (line 2 minus line 1).		$ 58,599	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 564,000	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.)**		$ 8,813	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 $ 35,774 For 08, 09 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.		$ 631,412	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2009	521,243	8
2010	444,758	9
2011	447,084	10
2012	461,637	11
2013	534,958	12

2014 Accrual = $537,562 x 1.05 = $564,000 (Rounded)

2014 Accrual includes non-care real estate taxes adjusted out on page 5A

Allocated from SIR Management = $8,641

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-25-323-003-0000	Long Term Care Property	$ 146,702.48	$ 146,702.48
2.	12-25-323-004-0000	Long Term Care Property	$ 146,559.61	$ 146,559.61
3.	12-25-323-005-0000	Long Term Care Property	$ 229,414.67	$ 229,414.67
4.	12-25-324-001-0000	Long Term Care Property	$ 6,600.45	$ 6,600.45
5.	12-25-324-002-0000	Long Term Care Property	$ 5,679.95	$ 5,679.95
6.	12-25-323-002-0000	Long Term Care Property	$ 2,604.46	$
7.	See Attaached	Allocation from S.I.R. Management	$ 116,016.54	$ 8,168.85
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 653,578.16	$ 543,126.01

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	245			1975	$ 10,419,509	$ 257,160	35	$ 297,700	$ 40,540	$ 6,059,449	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	129,203		20			129,189	9
10	Various			1994	49,738		20	1,131	1,131	49,732	10
11	Various			1995	167,102		20	8,226	8,226	163,091	11
12	Various			1996	136,090		20	6,805	6,805	124,947	12
13	Various			1997	16,180		20	809	809	14,195	13
14	Various			1998	158,155		20	6,538	6,538	134,537	14
15	Various			1999	121,088		20	6,054	6,054	94,039	15
16	Various			2000	67,583		20	3,379	3,379	48,869	16
17	Various			2001	107,654		20	5,383	5,383	73,192	17
18	Various			2002	113,214		20	624	624	112,400	18
19	Various			2003	145,109		20	6,702	6,702	88,181	19
20	Various			2004	124,757		20	5,559	5,559	64,944	20
21	Various			2005	84,119		20	4,706	4,706	46,257	21
22	Various			2006	127,687		20	6,917	6,917	58,047	22
23	Various			2007	117,180		20	6,773	6,773	51,506	23
24	Various			2008	56,513		20	2,826	2,826	18,509	24
25	Various			2009	123,292		20	7,159	7,159	39,249	25
26	Various			2010	254,770		20	12,739	12,739	59,302	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		3,088,888	109,140		154,444	45,304	917,250	67
68	Related Party Allocations (Pages 12H & 12I)		177,003	4,408		6,255	1,847	93,545	68
69	Financial Statement Depreciation			120,176			(120,176)		69
70	TOTAL (lines 4 thru 69)		$ 15,784,834	$ 490,884		$ 550,728	$ 59,844	$ 8,440,430	70

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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 15,784,834	$ 490,884		$ 550,728	$ 59,844	$ 8,440,430	1
2	Ventilators	2011	9,013		20	901	901	3,605	2
3	Window Screen Repairs	2011	2,886		20	144	144	469	3
4	Hallway Cabinetry	2012	2,880		20	144	144	420	4
5	Sprinkler Heads	2012	3,430		20	172	172	486	5
6	Sewage Pump	2012	4,395		20	220	220	641	6
7	Security Camera System	2012	9,153		20	458	458	1,335	7
8	Therapy Room Cabinetry	2012	9,800		20	490	490	1,307	8
9	Storage Room Cabinetry	2012	6,000		20	300	300	725	9
10	Fire Duct Detectors	2012	4,646		20	232	232	523	10
11	Boiler Work	2012	6,382		20	319	319	691	11
12	Install Handrails, Corner Guards And Crashrails	2012	3,248		20	162	162	352	12
13	Ffi-Fire Stop System	2013	5,990		20	300	300	524	13
14	Elevator Upgrades	2013	17,081		20	854	854	1,281	14
15	Hvac Repairs	2013	2,512		20	126	126	241	15
16	Nurse Call System - 1St Floor	2014	8,999		20	375	375	375	16
17	Doors And Installation	2014	10,188		20	297	297	297	17
18	Dietary Cabinets	2014	2,700		20	79	79	79	18
19	Doors (32)	2014	9,436		20	236	236	236	19
20	Replace Sumb & Balance Tray Strainers On Bac Cooling Tower	2014	3,321		20	166	166	166	20
21	Alley Ramp Repairs	2014	3,000		20	150	150	150	21
22	Replace Bearings On Bac Tower	2014	4,579		20	229	229	229	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)		$ 15,914,474	$ 490,884		$ 557,082	$ 66,198	$ 8,454,561	34

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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 15,914,474	$ 490,884		$ 557,082	$ 66,198	$ 8,454,561	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 15,914,474	$ 490,884		$ 557,082	$ 66,198	$ 8,454,561	34

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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 15,914,474	$ 490,884		$ 557,082	$ 66,198	$ 8,454,561	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 15,914,474	$ 490,884		$ 557,082	$ 66,198	$ 8,454,561	34

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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 15,914,474	$ 490,884		$ 557,082	$ 66,198	$ 8,454,561	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 15,914,474	$ 490,884		$ 557,082	$ 66,198	$ 8,454,561	34

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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9	HVAC Project	2008	1,560,000		20	78,000	78,000	546,000	9
10	Painting	2008	130,000		20	6,500	6,500	45,500	10
11	Elevator Cab	2008	43,612		20	2,181	2,181	15,264	11
12	Hand Rails	2008	15,105		20	755	755	5,287	12
13	Nurse Station	2008	112,920		20	5,646	5,646	39,522	13
14	Side Entry Hub	2008	8,245		20	412	412	2,886	14
15	Nurses Stations	2009	37,640		20	1,882	1,882	11,292	15
16	Window Treatement	2009	6,775		20	339	339	2,033	16
17	1st Floor Tile	2009	126,810		20	6,341	6,341	38,043	17
18	Resident Bathroom/Dayroom - Ceiling, Fixtures, Tiles, Paint	2009	202,085		20	10,104	10,104	60,626	18
19	Wiring	2009	10,034		20	502	502	3,010	19
20	Windows	2009	3,200		20	160	160	960	20
21	Lower Level Mall-Ceiling, Plumbing, Doors, Paint	2009	201,263		20	10,063	10,063	60,379	21
22	Painting	2009	15,000		20	750	750	4,500	22
23	Lower Level Mall-Drawings for Construction Permit	2009	9,000		20	450	450	2,700	23
24	2nd Floor Work	2009	23,400		20	1,170	1,170	7,020	24
25	2nd Floor Ceiling	2009	16,070		20	804	804	4,821	25
26	Sprinkler System Renovation	2009	11,017		20	551	551	3,305	26
27	Chair rail in dining Room	2009	11,312		20	566	566	3,394	27
28	Handrails - Floors 2,3,4	2009	44,652		20	2,233	2,233	13,396	28
29	Wallbase - Floors 2,3,4	2009	15,324		20	766	766	4,597	29
30	Tuckpointing	2011	61,030		20	3,052	3,052	12,206	30
31	Generator Project	2011	56,363		20	2,818	2,818	11,273	31
32	Replace, Resurface, & Restripe Asphalt Pavement	2013	13,500		20	675	675	1,350	32
33	Smoke Detectors	2013	3,229		20	161	161	323	33
34	TOTAL (lines 1 thru 33)		$ 2,737,586	$		$ 136,879	$ 136,879	$ 899,685	34

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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 2,737,586	$		$ 136,879	$ 136,879	$ 899,685	1
2	3rd Floor Tile Flooring	2014	143,845		20	7,192	7,192	7,192	2
3	2nd Floor Tile Flooring	2014	140,927		20	7,046	7,046	7,046	3
4	Lintel Replacement	2014	66,530		20	3,327	3,327	3,327	4
5									5
6	Building Company Improvement Depreciation			109,140			(109,140)		6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,088,888	$ 109,140		$ 154,444	$ 45,304	$ 917,250	34

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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3	Alloc. - S.I.R. Management	2009	22,477		39	576	576	2,906	3
4	Alloc. - S.I.R. Properties - S.I.R. Management	1993	40,698	1,292	35	1,163	(129)	25,000	4
5									5
6									6
7									7
8	Leasehold Information								8
9	Alloc. - S.I.R. Management	1993	10,318	287	20		(287)	10,318	9
10	Alloc. - S.I.R. Management	1994	32		20			32	10
11	Alloc. - S.I.R. Management	1995	236		20	12	12	229	11
12	Alloc. - S.I.R. Management	1997	15,855	355	20	773	418	14,043	12
13	Alloc. - S.I.R. Management	1999	1,247		20	62	62	950	13
14	Alloc. - S.I.R. Management	1999	13,707		20			13,707	14
15	Alloc. - S.I.R. Management	2000	1,472		20	74	74	1,070	15
16	Alloc. - S.I.R. Management	2007	4,729	323	20	236	(87)	1,701	16
17	Alloc. - S.I.R. Management	2008	13,033	1,245	20	821	(424)	5,623	17
18	Alloc. - S.I.R. Management	2009	32,385	296	20	1,619	1,323	8,492	18
19	Alloc. - S.I.R. Management	2011	801	80	20	80		274	19
20	Alloc. - S.I.R. Management	2012	2,564	128	20	128		310	20
21	Alloc. - S.I.R. Management	2014	360		20	11	11	11	21
22									22
23	Alloc. - S.I.R. Properties - S.I.R. Management	2012	2,493	245	20	12	(233)	32	23
24	Alloc. - S.I.R. Properties - S.I.R. Management	2010	2,456		20	123	123	532	24
25	Alloc. - S.I.R. Properties - S.I.R. Management	2009	2,444	109	20	122	13	709	25
26	Alloc. - S.I.R. Properties - S.I.R. Management	2007	713	35	20	36	1	285	26
27	Alloc. - S.I.R. Properties - S.I.R. Management	2002	161		20	8	8	101	27
28	Alloc. - S.I.R. Properties - S.I.R. Management	1999	5,157		20	258	258	3,997	28
29	Alloc. - S.I.R. Properties - S.I.R. Management	1998	2,464		20	123	123	2,033	29
30	Alloc. - S.I.R. Properties - S.I.R. Management	1997	153		20	8	8	142	30
31	Alloc. - S.I.R. Properties - S.I.R. Management	1994	388	10	20	10		388	31
32	Alloc. - S.I.R. Properties - S.I.R. Management	1993	660	3	20		(3)	660	32
33									33
34	TOTAL (lines 1 thru 33)		$ 177,003	$ 4,408		$ 6,255	$ 1,847	$ 93,545	34

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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 177,003	$ 4,408		$ 6,255	$ 1,847	$ 93,545	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 177,003	$ 4,408		$ 6,255	$ 1,847	$ 93,545	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,590,806	$ 63,452	$ 226,689	$ 163,237	10	$ 1,268,718	71
72	Current Year Purchases	73,128	166	4,869	4,703	10	4,869	72
73	Fully Depreciated Assets	582,469				10	582,469	73
74								74
75	TOTALS	$ 3,246,403	$ 63,618	$ 231,558	$ 167,940		$ 1,856,055	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from SIR Management	2014	$ 3,160	$ 286	$ 338	$ 52	5	$ 1,821	76
77										77
78										78
79										79
80	TOTALS			$ 3,160	$ 286	$ 338	$ 52		$ 1,821	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)	$ 19,889,028	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 554,788	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 788,978	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 234,190	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 10,312,438	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	Land	$ 155,000	$	$	86
87	Demolish & Remove House	24,540			87
88					88
89					89
90					90
91	TOTALS	$ 179,540	$	$	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2015	$
13.	/2016	$
14.	/2017	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 8,290 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from SIR Management		$	$ 6,126	17
18					18
19					19
20					20
21	TOTAL		$	$ 6,126	21

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

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 193,710	$		$ 193,710	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			205,623			205,623	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			309,435			309,435	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				361,197		361,197	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			964,526		206,402	368,547		1,539,475	13
14	TOTAL			$ 964,526		$ 915,170	$ 729,744		$ 2,609,440	14

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

STATE OF ILLINOIS

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 95,670	$ 3,070,527	1
2	Cash-Patient Deposits	71,926	71,926	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,049,391	3,049,391	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	98,652	98,652	6
7	Other Prepaid Expenses	5,790	5,790	7
8	Accounts Receivable (owners or related parties)	292,593		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,614,022	$ 6,296,286	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		882,991	13
14	Buildings, at Historical Cost		10,419,509	14
15	Leasehold Improvements, at Historical Cost	1,086,541	4,173,401	15
16	Equipment, at Historical Cost	2,833,859	4,189,969	16
17	Accumulated Depreciation (book methods)	(2,574,354)	(9,976,425)	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):	200,000	443,205	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,546,046	$ 10,132,650	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,160,068	$ 16,428,936	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 551,840	$ 607,363	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	71,926	71,926	28
29	Short-Term Notes Payable	2,550,000	2,550,000	29
30	Accrued Salaries Payable	521,655	521,655	30
31	Accrued Taxes Payable (excluding real estate taxes)	116,226	116,226	31
32	Accrued Real Estate Taxes(Sch.IX-B)		564,000	32
33	Accrued Interest Payable		35,456	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	93,036	119,566	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,904,683	$ 4,586,192	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)**	$ 3,904,683	$ 20,486,192	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,255,385	$ (4,057,256)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,160,068	$ 16,428,936	48

*(See instructions.)

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,170,104	1	
2	Restatements (describe):		2	
3	Rounding	8	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,170,112	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	668,473	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	(583,200)	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)**	$ 85,273	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)**	$ 1,255,385	24	*

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 16,174,337	1
2	Discounts and Allowances for all Levels	(2,095,369)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 14,078,968	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,566,568	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,566,568	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	289,707	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,274	19
20	Radiology and X-Ray	11,604	20
21	Other Medical Services	736,397	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,064,982	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,000	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,000	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	352,058	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 352,058	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 18,064,576	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,368,974	31
32	Health Care	5,922,890	32
33	General Administration	3,727,333	33
	B. Capital Expense		
34	Ownership	2,171,218	34
	C. Ancillary Expense		
35	Special Cost Centers	2,684,783	35
36	Provider Participation Fee	520,905	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,396,103	40
41	**Income before Income Taxes (line 30 minus line 40)****	668,473	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 668,473	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,712,996	44
45	Private Pay - Net Inpatient Revenue	398,512	45
46	Medicare - Net Inpatient Revenue	1,330,412	46
47	Other-(specify) VA	119,111	47
48	Other-(specify) Hospice/HMO/Ins	3,517,937	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 14,078,968	49

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

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

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

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,997	2,086	$ 139,240	$ 66.75	1
2	Assistant Director of Nursing	1,803	2,006	90,178	44.95	2
3	Registered Nurses	35,439	37,873	1,134,972	29.97	3
4	Licensed Practical Nurses	48,025	53,464	1,473,955	27.57	4
5	CNAs & Orderlies	114,161	120,825	1,328,739	11.00	5
6	CNA Trainees					6
7	Licensed Therapist	38,176	41,706	964,526	23.13	7
8	Rehab/Therapy Aides	13,677	15,175	293,355	19.33	8
9	Activity Director	1,867	2,158	41,492	19.23	9
10	Activity Assistants	8,259	9,055	83,789	9.25	10
11	Social Service Workers	14,424	15,757	255,780	16.23	11
12	Dietician					12
13	Food Service Supervisor	3,548	3,910	73,675	18.84	13
14	Head Cook	5,092	5,559	57,323	10.31	14
15	Cook Helpers/Assistants	21,472	23,544	246,111	10.45	15
16	Dishwashers					16
17	Maintenance Workers	6,617	6,814	92,336	13.55	17
18	Housekeepers	25,317	28,577	284,129	9.94	18
19	Laundry	11,420	12,759	122,073	9.57	19
20	Administrator	2,005	2,086	131,764	63.17	20
21	Assistant Administrator	1,893	2,126	74,437	35.01	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,860	16,036	210,427	13.12	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	10,181	11,110	279,662	25.17	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,528	2,647	75,343	28.46	33
34	TOTAL (lines 1 - 33)	382,761	415,273	$ 7,453,306 *	$ 17.95	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 36,151	01-03	35
36	Medical Director	Monthly	28,300	09-03	36
37	Medical Records Consultant	Monthly	4,248	10-03	37
38	Nurse Consultant	Monthly	70,560	10-03	38
39	Pharmacist Consultant	Monthly	14,640	10-03	39
40	Physical Therapy Consultant	33	2,316	10a-03	40
41	Occupational Therapy Consultant	10	703	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	107	5,592	10a-03	43
44	Activity Consultant	Monthly	2,401	11-03	44
45	Social Service Consultant				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)	150	$ 217,831		49

C. CONTRACT NURSES

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Colleen Swanson	Administrator	0	$ 131,764
Barbara Dabrowski	Asst. Admin	0	73,917
Andrea Alanis	Asst. Admin	0	520
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 206,201

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	823,230
TOTAL (agree to Schedule V, line 17, col. 3)	$ 952,590
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 14,650
Plante & Moran	Accounting	6,125
McGladrey	Accounting	2,900
SIR Management	Director of Financial Services	36,000
SIR Management	Dir. Of Regulatory Services	35,280
SIR Management	Bookkeeping	120,540
Personnel Planners	Unemployment Tax Consult	2,353
Amari & Locallo	RE Tax Assessment	8,018
Pinnacle	Customer Satisfaction	3,341
E-Health Data	Data Processing	3,300
Achieve Accreditation	Accreditation	7,010
See Supplemental Schedule		13,377
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 252,893

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 96,952
Unemployment Compensation Insurance	80,574
FICA Taxes	559,048
Employee Health Insurance	310,741
Employee Meals	44,983
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension Plan	37,281
401K Contribution	12,320
Other Employee Benefits	17,545
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,159,443

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,988
Advertising: Employee Recruitment	4,983
Health Care Worker Background Check	
(Indicate # of checks performed 466.6)	4,666
Patient Background Checks	
Dues & Subscriptions	18,274
Licenses & Fees	8,262
Allocated from SIR Management	3,320
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 41,493

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	8,642
Allocated from SIR Management	931
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,573

**See instructions.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/14 Ending: 12/31/14

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC: $19,970**

(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. $ **28,112** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **520,905**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **44,983** Has any meal income been offset against related costs? **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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.