FOR BHF USE

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2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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

I. IDPH License ID Number: 0040410

Facility Name: Elmwood Care

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

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 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) 282-6300
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 01/01/15 to 12/31/15 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)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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: 01/01/15 Ending: 12/31/15

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	37,650	1,201	27,022	65,873	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,650	1,201	27,022	65,873	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.66%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 245 and days of care provided 5,996

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: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Elmwood Care # 0040410 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	383,594	46,237	65,496	495,327		495,327	(20,761)	474,566			1
2	Food Purchase		380,907		380,907	(47,830)	333,077	(69)	333,008			2
3	Housekeeping	289,412	94,385		383,797		383,797		383,797			3
4	Laundry	119,581	56,422		176,003		176,003		176,003			4
5	Heat and Other Utilities			294,310	294,310		294,310	(14,006)	280,304			5
6	Maintenance	80,474	53,255	297,052	430,781		430,781	(2,455)	428,326			6
7	Other (specify):*							15,434	15,434			7
8	**TOTAL General Services**	873,061	631,206	656,858	2,161,125	(47,830)	2,113,295	(21,858)	2,091,438			8
	B. Health Care and Programs											
9	Medical Director			39,080	39,080		39,080		39,080			9
10	Nursing and Medical Records	4,393,546	899,623	83,892	5,377,061		5,377,061	(110,489)	5,266,572			10
10a	Therapy	294,644		40,000	334,644		334,644	(11,219)	323,425			10a
11	Activities	104,299	4,648	2,496	111,443		111,443		111,443			11
12	Social Services	189,096		2,819	191,915		191,915		191,915			12
13	CNA Training											13
14	Program Transportation			13,777	13,777		13,777		13,777			14
15	Other (specify):*							7,183	7,183			15
16	**TOTAL Health Care and Programs**	4,981,585	904,271	182,064	6,067,920		6,067,920	(114,524)	5,953,396			16
	C. General Administration											
17	Administrative	200,998		957,449	1,158,447		1,158,447	(828,869)	329,578			17
18	Directors Fees											18
19	Professional Services			397,546	397,546	(12,684)	384,862	(256,883)	127,978			19
20	Dues, Fees, Subscriptions & Promotions			83,457	83,457		83,457	(40,818)	42,639			20
21	Clerical & General Office Expenses	278,990	52,707	761,422	1,093,119		1,093,119	(562,552)	530,567			21
22	Employee Benefits & Payroll Taxes			1,171,670	1,171,670	47,830	1,219,500		1,219,500			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,592	3,592		3,592	1,707	5,299			24
25	Other Admin. Staff Transportation			5,084	5,084		5,084	8,235	13,319			25
26	Insurance-Prop.Liab.Malpractice			251,933	251,933		251,933	2,745	254,678			26
27	Other (specify):*							46,517	46,517			27
28	**TOTAL General Administration**	479,988	52,707	3,632,153	4,164,848	35,145	4,199,993	(1,629,919)	2,570,075			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,334,634	1,588,184	4,471,075	12,393,893	(12,684)	12,381,209	(1,766,300)	10,614,908			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:** 01/01/15 **Ending:** 12/31/15

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			122,612	122,612		122,612	678,633	801,245			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			121,060	121,060		121,060	824,216	945,276			32
33	Real Estate Taxes					12,684	12,684	574,244	586,928			33
34	Rent-Facility & Grounds			1,944,000	1,944,000		1,944,000	(1,944,000)				34
35	Rent-Equipment & Vehicles			6,201	6,201		6,201	7,829	14,030			35
36	Other (specify):*							116,733	116,733			36
37	**TOTAL Ownership**			2,193,873	2,193,873	12,684	2,206,557	257,655	2,464,212			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	918,879	775,308	986,419	2,680,606		2,680,606	(3,998)	2,676,608			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			502,630	502,630		502,630	(3,363)	499,267			42
43	Other (specify):*	79,015			79,015		79,015	(79,015)	(0)			43
44	**TOTAL Special Cost Centers**	997,894	775,308	1,489,049	3,262,251		3,262,251	(86,376)	3,175,875			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,332,528	2,363,492	8,153,997	17,850,017	0	17,850,017	(1,595,022)	16,254,995			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: 01/01/15 Ending: 12/31/15

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	(16,776)	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	218,745	30		9
10	Interest and Other Investment Income	(7,851)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(69)	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	(14,323)	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	(671,992)	21		24
25	Fund Raising, Advertising and Promotional	(18,369)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(9,500)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(332,644)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (852,779)		$	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)	(742,243)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (742,243)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,595,022)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Elmwood Care

ID# 0040410

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (77)	21	1
2	Purchased Services - VA	(42,947)	10	2
3	Legal Fees - Collections	(10,896)	19	3
4	Bank Fees	(6,640)	21	4
5	Theft & Damage	(3,045)	21	5
6	Bldg. Co. - Filing Fees	(500)	21	6
7	Bldg. Co. - Amortization	(48,241)	36	7
8	Bldg. Co. - Office Expense	(550)	21	8
9	Bldg. Co. - Professional Fees	(54,374)	19	9
10	Marketing Salary	(79,015)	43	10
11	PAC Dues	(10,045)	20	11
12	Non-Care Real Estate Taxes	(3,945)	33	12
13	Additional R&M	4,357	06	13
14	Capitalized R&M	(18,578)	06	14
15	Non Allowable Legal Fees	(10,080)	19	15
16	PPA - Nursing Equipment Rental	(7,090)	10	16
17	2015 Seminar	315	24	17
18	PPA - Provider Assessment	(3,363)	42	18
19	PPA - Medical Supply	(37,929)	10	19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(332,644)		49

Elmwood Care

ID# 0040410

Report Period Beginning: 01/01/15

Ending: 12/31/15

	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			49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Elmwood Care **#** 0040410 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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				(20,761)								(20,761)	1
2	Food Purchase	(69)											(69)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(16,776)			2,770								(14,006)	5
6	Maintenance	(14,221)	5,700	(29,470)	35,536								(2,455)	6
7	Other (specify):*				15,434								15,434	7
8	**TOTAL General Services**	(31,066)	5,700	(29,470)	32,979								(21,858)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(87,966)		(31,111)	9,528	(939)							(110,489)	10
10a	Therapy				(11,219)								(11,219)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			4,133	3,050								7,183	15
16	**TOTAL Health Care and Programs**	(87,966)		(26,978)	1,360	(939)							(114,524)	16
	C. General Administration													
17	Administrative			(926,475)	97,606								(828,869)	17
18	Directors Fees													18
19	Professional Services	(75,349)	54,374	(254,463)	18,555								(256,883)	19
20	Fees, Subscriptions & Promotions	(42,737)		1,919									(40,818)	20
21	Clerical & General Office Expenses	(692,304)	1,050	128,579	123								(562,552)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	315		1,392									1,707	24
25	Other Admin. Staff Transportation			8,235									8,235	25
26	Insurance-Prop.Liab.Malpractice			2,477	268								2,745	26
27	Other (specify):*			25,464	21,053								46,517	27
28	**TOTAL General Administration**	(810,076)	55,424	(1,012,872)	137,605								(1,629,919)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(929,108)	61,124	(1,069,320)	171,943	(939)							(1,766,300)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Elmwood Care # 0040410 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	218,745	451,315		8,573								678,633	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(7,851)	841,034	(16,591)	7,624								824,216	32
33	Real Estate Taxes	(3,945)	568,293		9,896								574,244	33
34	Rent-Facility & Grounds		(1,944,000)										(1,944,000)	34
35	Rent-Equipment & Vehicles			7,829									7,829	35
36	Other (specify):*	(48,241)	164,974										116,733	36
37	**TOTAL Ownership**	158,708	81,616	(8,762)	26,093								257,655	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(3,899)	(99)						(3,998)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee	(3,363)											(3,363)	42
43	Other (specify):*	(79,015)											(79,015)	43
44	**TOTAL Special Cost Centers**	(82,378)				(3,899)	(99)						(86,376)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(852,779)	142,740	(1,078,082)	198,036	(4,838)	(99)						(1,595,022)	45

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	21	Filing Fees		Elmwood Grand, LLC	100.00%	500	500	2
3	V	32	Interest	1,398	Elmwood Grand, LLC	100.00%	842,432	841,034	3
4	V	36	Mortgage Insurance		Elmwood Grand, LLC	100.00%	116,733	116,733	4
5	V	21	Office Expense		Elmwood Grand, LLC	100.00%	550	550	5
6	V	19	Professional Fees		Elmwood Grand, LLC	100.00%	54,374	54,374	6
7	V	33	Real Estate	11,707	Elmwood Grand, LLC	100.00%	580,000	568,293	7
8	V	06	Repairs		Elmwood Grand, LLC	100.00%	5,700	5,700	8
9	V	36	Amortization of HUD Fees		Elmwood Grand, LLC	100.00%	5,593	5,593	9
10	V	36	Amortization of Loan Fees		Elmwood Grand, LLC	100.00%	42,648	42,648	10
11	V	30	Depreciation		Elmwood Grand, LLC	100.00%	451,315	451,315	11
12	V								12
13	V								13
14	Total			$ 1,957,105			$ 2,099,845	$ * 142,740	14

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/15 Ending: 12/31/15

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.	$ 35,280	S.I.R. MANAGEMENT, INC.	100.00%	$ 5,810	$ (29,470)	15
16	V								16
17	V	10	NURSING	76,440	S.I.R. MANAGEMENT, INC.	100.00%	45,329	(31,111)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	4,133	4,133	18
19	V	19	PROFESSIONAL FEES	259,680	S.I.R. MANAGEMENT, INC.	100.00%	4,690	(254,990)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	1,919	1,919	20
21	V	21	CLERICAL & GENERAL	35,280	S.I.R. MANAGEMENT, INC.	100.00%	146,988	111,708	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	1,392	1,392	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	8,235	8,235	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	2,477	2,477	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	7,782	7,782	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(16,591)	(16,591)	26
27	V	35	AUTO RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	6,655	6,655	27
28	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	1,174	1,174	28
29	V								29
30	V	17	ADMINISTRATIVE	957,449	S.I.R. MANAGEMENT, INC.	100.00%	30,974	(926,475)	30
31	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	527	527	31
32	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	16,871	16,871	32
33	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	17,682	17,682	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,364,129			$ 286,047	$ * (1,078,082)	39

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	$ 8,639	$ (20,761)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,205	1,205	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	9,528	9,528	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	1,319	1,319	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	97,606	97,606	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	18,463	18,463	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	21,053	21,053	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	23,520	S.I.R. MANAGEMENT, INC.	100.00%	12,301	(11,219)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,731	1,731	25
26	V								26
27	V	6	MAINTENANCE SALARIES	61,101	S.I.R. MANAGEMENT, INC.	100.00%	95,081	33,980	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	14,229	14,229	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	2,770	2,770	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	1,556	1,556	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	92	92	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	123	123	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	268	268	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	8,573	8,573	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	7,624	7,624	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	9,896	9,896	37
38	V								38
39	Total			$ 114,021			$ 312,057	$ * 198,036	39

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	$ 71,141	MAC Rx, LLC	100.00%	$ 70,202	$ (939)	15
16	V	39	Ancillary	295,254	MAC Rx, LLC	100.00%	291,355	(3,899)	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			$ 366,396			$ 361,557	$ * (4,838)	39

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 11,915	Long Term Care Laboratory, LLC	100.00%	$ 11,816	$ (99)	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			$ 11,915			$ 11,816	$ * (99)	39

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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	2.88%	ALBANY CARE INC	EVANSTON	ELMWOOD-GRAND, LLC	LINCOLNWOOD	Building Co.	1
2	BRYAN BARRISH TRUST DTD 09/01/2004	14.25%	APPLEWOOD REHABILITATION CENTER,LLC	MATTESON	SIR MANAGEMENT	LINCOLNWOOD	Management Co.	2
3	CELESTE GIANNINI TRUST DTD 3/13/00	17.75%	BRYN MAWR CARE INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	Building Co.	3
4	DANIEL ROTHNER TRUST	2.88%	COLUMBUS PARK NURSING & REHABILITATION CENTER, INC.	CHICAGO	LONG TERM CARE LABORATO	ELK GROVE VILLAGE	Laboratory	4
5	DENNIS TOSSI	0.82%	DECATUR MANOR HEALTHCARE,LLC	DECATUR	OAKTON ARMS	DES PLAINES	Assisted Living	5
6	GALE ROTHNER	9.47%	GREENWOOD CARE, INC.	EVANSTON	MAX RX, LLC	DES PLAINES	Pharmacy	6
7	HARVEY SCOTT	0.82%	NEIGHBORS REHABILITATION CENTER,LLC	BYRON				7
8	JEFF ORAVEC	0.41%	REGENCY REHABILITATION CENTER,LLC	NILES				8
9	JOEY ABRAMCHIK	2.06%	ROCK ISLAND NURSING & REHAB CENTER,LLC	ROCK ISLAND				9
10	JULIANA R. BARRISH TRUST DTD 1/26/93	14.25%	WILSON CARE, INC.	CHICAGO				10
11	KATHRYN VALES TRUST	2.88%	WESLEY REHABILITATION CENTER	AUBURN, IN				11
12	KIMBERLY RICHMAN TRUST	2.88%	OAKTON PAVILION	DES PLAINES				12
13	LORI BARRISH	2.06%						13
14	LOUISE BERGTHOLD	4.94%						14
15	MELISSA ROTHNER TRUST	2.88%						15
16	MICHAEL R GIANNINI TRUST DTD 3/13/00	11.57%						16
17	RACHEL ROTHNER TRUST	2.88%						17
18	THOMAS WINTER	1.44%						18
19	WILLIAM ROTHNER TRUST	2.88%						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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Bryan Barrish	Relative	Administrative	0	See Attached	3.65	8.11%	Alloc. Salary	$ 18,267	17-7	1
2	Michael Giannini	Relative	Administrative	0	See Attached	3.20	8.00%	Alloc. Salary	15,616	17-7	2
3	Nenita Guzman	Relative	Dietary	0	See Attached	4.57	9.14%	Alloc. Salary	8,639	1-7	3
4	Sarah Barrish	Relative	Administrative	0	See Attached	4.11	9.13%	Alloc. Salary	9,622	17-7	4
5	Kirsten Schloss	Relative	Maintenance	0	See Attached	4.57	9.14%	Alloc. Salary	8,798	6-7	5
6	Jeff Oravec	Shareholder	Administrative	0.41%	See Attached	3.65	9.13%	Alloc. Salary	12,706	17-7	6
7	Tom Winter	Shareholder	Administrative	1.44%	See Attached	5.48	9.13%	Alloc. Salary	18,267	17-7	7
8	Louise Bergthold	Shareholder	Administrative	4.94%	See Attached	5.48	9.13%	Alloc. Salary	18,267	17-7	8
9	Joey Abramchik	Shareholder	Administrative	2.06%	See Attached	3.65	9.13%	Alloc. Salary	18,463	17-7	9
10	See Supplemental Schedule								7,698		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	$ 136,343		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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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	721,222	14	$ 63,617	$	65,873	$ 5,810	1
2										2
3	10	NURSING	PATIENT DAYS	721,222	14	496,290	496,290	65,873	45,329	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	721,222	14	45,246		65,873	4,133	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	721,222	14	51,349		65,873	4,690	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	721,222	14	21,010		65,873	1,919	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	721,222	14	1,609,327	1,193,369	65,873	146,988	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	721,222	14	15,238		65,873	1,392	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	721,222	14	90,162		65,873	8,235	9
10	26	INSURANCE	PATIENT DAYS	721,222	14	27,120		65,873	2,477	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	721,222	14	85,206		65,873	7,782	11
12	32	INTEREST	PATIENT DAYS	721,222	14	(181,648)		65,873	(16,591)	12
13	35	AUTO RENTAL	PATIENT DAYS	721,222	14	72,863		65,873	6,655	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	721,222	14	12,850		65,873	1,174	14
15										15
16	17	ADMINISTRATIVE	PATIENT DAYS	721,222	14	339,119	339,119	65,873	30,974	16
17	19	PROFESSIONAL FEES	PATIENT DAYS	721,222	14	5,774		65,873	527	17
18	21	CLERICAL & GENERAL	PATIENT DAYS	721,222	14	184,716	77,164	65,873	16,871	18
19	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	721,222	14	193,599		65,873	17,682	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,131,838	$ 2,105,942		$ 286,047	25

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	721,222	14	$ 94,587	$ 94,587	65,873	$ 8,639	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	721,222	14	13,188		65,873	1,205	2
3	10	NURSING SALARIES	PATIENT DAYS	721,222	14	104,315	104,315	65,873	9,528	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	721,222	14	14,440		65,873	1,319	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	721,222	14	1,068,659	1,068,659	65,873	97,606	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	721,222	14	202,147		65,873	18,463	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	721,222	14	230,505		65,873	21,053	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	322,920	13	168,894	168,894	23,520	12,301	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	322,920	13	23,767		23,520	1,731	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	319,657	14	497,427	497,427	61,101	95,081	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	319,657	14	74,439		61,101	14,229	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,878	14	30,338		1,176	2,770	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,878	14	17,037		1,176	1,556	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,878	14	1,002		1,176	92	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,878	14	1,351		1,176	123	19
20	26	INSURANCE	ALLOCATED SQ FT	12,878	14	2,937		1,176	268	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,878	14	93,883		1,176	8,573	21
22	32	INTEREST	ALLOCATED SQ FT	12,878	14	83,486		1,176	7,624	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,878	14	108,372		1,176	9,896	23
24										24
25	TOTALS					$ 2,830,774	$ 1,933,882		$ 312,057	25

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: MAC Rx, LLC
Street Address: 2307 S. Mount Prospect Road
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (224)220-2700
Fax Number: (224)220-2730

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing And Medical Records	Direct Allocation			$	$		$ 70,202	1
2	39	Ancillary	Direct Allocation						291,355	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					$	$		$ 361,557	25

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			$	$		$ 11,816	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					$	$		$ 11,816	25

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	First Merit Bank		X	Mortgage			$	$ 16,307,429			$ 842,432	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Wintrust		X	Line of Credit				2,650,000			121,060	6
7												7
8												8
9	TOTAL Facility Related						$	$ 18,957,429			$ 963,492	9
	B. Non-Facility Related*											
10	Interest Income		X								(7,851)	10
11	Interest Income - Bldg. Co.		X								(1,398)	11
12	Allocated from SIR Mgmt.	X									(8,967)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (18,216)	14
15	TOTALS (line 9+line14)						$	$ 18,957,429			$ 945,276	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 116,733 **Line #** 36

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

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/15 Ending: 12/31/15

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							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											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:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 564,000	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.)		$ 558,244	2
3. Under or (over) accrual (line 2 minus line 1).		$ (5,756)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 580,000	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.**		$ 12,684	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** $ 50,738 **For** 2011 **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.		$ 586,928	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	444,758	8
	2011	447,084	9
	2012	461,637	10
	2013	534,958	11
	2014	548,348	12

2015 Accrual = $552,293 x 1.05 = $ 580,000 (Rounded)
Allocated from SIR Management = $9,896

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 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 2014 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 2014.

	(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	$ 150,374.90	$ 150,374.90
2.	12-28-323-004-0000	Long Term Care Property	$ 150,228.28	$ 150,228.28
3.	12-25-323-005-0000	Long Term Care Property	$ 235,157.52	$ 235,157.52
4.	12-25-324-001-0000	Long Term Care Property	$ 6,765.61	$ 6,765.61
5.	12-25-324-002-0000	Long Term Care Property	$ 5,822.07	$ 5,822.07
6.	12-25-323-002-0000	Long Term Care Property	$ 3,944.76	$
7.	See Attached	Allocation from SIR Management	$ 118,674.75	$ 8,487.22
8.	10-31-401-046-0000	Allocation from Regency Property	$ 862,948.02	$ 956.67
9.			$	$
10.			$	$
		TOTALS	$ 1,533,915.91	$ 557,792.27

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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	$ 6,357,149	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			49,732	10
11	Various			1995	167,102		20	4,008	4,008	167,099	11
12	Various			1996	136,090		20	6,805	6,805	131,751	12
13	Various			1997	16,180		20	809	809	15,004	13
14	Various			1998	158,155		20	6,538	6,538	141,075	14
15	Various			1999	121,088		20	6,054	6,054	100,094	15
16	Various			2000	67,583		20	3,379	3,379	52,248	16
17	Various			2001	107,654		20	5,383	5,383	78,575	17
18	Various			2002	113,214		20	305	305	112,705	18
19	Various			2003	145,109		20	6,702	6,702	94,883	19
20	Various			2004	124,757		20	6,521	6,521	71,465	20
21	Various			2005	84,119		20	3,908	3,908	50,165	21
22	Various			2006	127,687		20	6,917	6,917	64,965	22
23	Various			2007	117,180		20	6,773	6,773	58,279	23
24	Various			2008	56,513		20	2,826	2,826	21,334	24
25	Various			2009	123,292		20	7,159	7,159	46,408	25
26	Various			2010	254,770		20	12,739	12,739	72,041	26
27	Various			2011	11,899		20	1,046	1,046	5,120	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: 01/01/15 Ending: 12/31/15

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)		3,357,785	132,074		167,889	35,815	1,085,138	67
68	Related Party Allocations (Pages 12H & 12I)		202,396	5,326		6,927	1,601	104,673	68
69	Financial Statement Depreciation			122,612			(122,612)		69
70	TOTAL (lines 4 thru 69)		$ 16,091,024	$ 517,172		$ 560,388	$ 43,216	$ 9,009,092	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: 01/01/15 Ending: 12/31/15

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		$ 16,091,024	$ 517,172		$ 560,388	$ 43,216	$ 9,009,092	1
2	Hallway Cabinetry	2012	2,880		20	144	144	564	2
3	Sprinkler Heads	2012	3,430		20	172	172	657	3
4	Sewage Pump	2012	4,395		20	220	220	861	4
5	Security Camera System	2012	9,153		20	458	458	1,792	5
6	Therapy Room Cabinetry	2012	9,800		20	490	490	1,797	6
7	Storage Room Cabinetry	2012	6,000		20	300	300	1,025	7
8	Fire Duct Detectors	2012	4,646		20	232	232	755	8
9	Boiler Work	2012	6,382		20	319	319	1,010	9
10	Install Handrails, Corner Guards And Crashrails	2012	3,248		20	162	162	514	10
11	Ffi-Fire Stop System	2013	5,990		20	300	300	824	11
12	Elevator Upgrades	2013	17,081		20	854	854	2,135	12
13	Hvac Repairs	2013	2,512		20	126	126	366	13
14	Nurse Call System - 1St Floor	2014	8,999		20	450	450	825	14
15	Doors And Installation	2014	10,188		20	509	509	807	15
16	Dietary Cabinets	2014	2,700		20	135	135	214	16
17	Doors (32)	2014	9,436		20	472	472	708	17
18	Replace Sumb & Balance Tray Strainers On Bac Cooling Tower	2014	3,321		20	166	166	277	18
19	Alley Ramp Repairs	2014	3,000		20	150	150	238	19
20	Replace Bearings On Bac Tower	2014	4,579		20	229	229	324	20
21	Circuit Breakers In Control Room	2014	2,500		20	125	125	125	21
22	Metal Door & Frame	2015	2,690		20	179	179	179	22
23	Grade Parking Lot	2015	6,200		20	233	233	233	23
24	New Carpet - Admissions Office	2015	4,933		20	21	21	21	24
25	Handrail Repairs	2015	3,397		20	14	14	14	25
26	Repair Walk In Freezer	2015	2,696		20	135	135	135	26
27	Fire Alarm, Jockey Pump, & Value Replacement	2015	2,596		20	130	130	130	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 16,233,775	$ 517,172		$ 567,111	$ 49,939	$ 9,025,620	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: 01/01/15 Ending: 12/31/15

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		$ 16,233,775	$ 517,172		$ 567,111	$ 49,939	$ 9,025,620	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)		$ 16,233,775	$ 517,172		$ 567,111	$ 49,939	$ 9,025,620	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: 01/01/15 Ending: 12/31/15

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		$ 16,233,775	$ 517,172		$ 567,111	$ 49,939	$ 9,025,620	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)		$ 16,233,775	$ 517,172		$ 567,111	$ 49,939	$ 9,025,620	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: 01/01/15 Ending: 12/31/15

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		$ 16,233,775	$ 517,172		$ 567,111	$ 49,939	$ 9,025,620	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)		$ 16,233,775	$ 517,172		$ 567,111	$ 49,939	$ 9,025,620	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: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	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	624,000	9
10	Painting	2008	130,000		20	6,500	6,500	52,000	10
11	Elevator Cab	2008	43,612		20	2,181	2,181	17,445	11
12	Hand Rails	2008	15,105		20	755	755	6,042	12
13	Nurse Station	2008	112,920		20	5,646	5,646	45,168	13
14	Side Entry Hub	2008	8,245		20	412	412	3,298	14
15	Nurses Stations	2009	37,640		20	1,882	1,882	13,174	15
16	Window Treatement	2009	6,775		20	339	339	2,371	16
17	1st Floor Tile	2009	126,810		20	6,341	6,341	44,384	17
18	Resident Bathroom/Dayroom - Ceiling, Fixtures, Tiles, Paint	2009	202,085		20	10,104	10,104	70,730	18
19	Wiring	2009	10,034		20	502	502	3,512	19
20	Windows	2009	3,200		20	160	160	1,120	20
21	Lower Level Mall-Ceiling, Plumbing, Doors, Paint	2009	201,263		20	10,063	10,063	70,442	21
22	Painting	2009	15,000		20	750	750	5,250	22
23	Lower Level Mall-Drawings for Construction Permit	2009	9,000		20	450	450	3,150	23
24	2nd Floor Work	2009	23,400		20	1,170	1,170	8,190	24
25	2nd Floor Ceiling	2009	16,070		20	804	804	5,625	25
26	Sprinkler System Renovation	2009	11,017		20	551	551	3,856	26
27	Chair rail in dining Room	2009	11,312		20	566	566	3,959	27
28	Handrails - Floors 2,3,4	2009	44,652		20	2,233	2,233	15,628	28
29	Wallbase - Floors 2,3,4	2009	15,324		20	766	766	5,363	29
30	Tuckpointing	2011	61,030		20	3,052	3,052	15,258	30
31	Generator Project	2011	56,363		20	2,818	2,818	14,091	31
32	Replace, Resurface, & Restripe Asphalt Pavement	2013	13,500		20	675	675	2,025	32
33	Smoke Detectors	2013	3,229		20	161	161	484	33
34	TOTAL (lines 1 thru 33)		$ 2,737,586	$		$ 136,879	$ 136,879	$ 1,036,564	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: 01/01/15 Ending: 12/31/15

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	$ 1,036,564	1
2	3rd Floor Tile Flooring	2014	143,845		20	7,192	7,192	14,385	2
3	2nd Floor Tile Flooring	2014	140,927		20	7,046	7,046	14,093	3
4	Lintel Replacement	2014	66,530		20	3,327	3,327	6,653	4
5	Elevator Grab-Bar & Signage	2015	3,063		20	153	153	153	5
6	Windows - Entire Facility	2015	124,906		20	6,245	6,245	6,245	6
7	Flooring - 4th Floor	2015	140,928		20	7,046	7,046	7,046	7
8									8
9	Building Company Improvement Depreciation			132,074			(132,074)		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)		$ 3,357,785	$ 132,074		$ 167,889	$ 35,815	$ 1,085,138	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: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Alloc. - S.I.R. Management	2009	45,659	1,171	39	1,171		7,073	3
4	Alloc. - S.I.R. Properties - S.I.R. Management	1993	41,337	1,312	35	1,181	(131)	26,573	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Alloc. - S.I.R. Management	1993	10,480	292	20		(292)	10,480	9
10	Alloc. - S.I.R. Management	1994	33		20			33	10
11	Alloc. - S.I.R. Management	1995	240		20	7	7	239	11
12	Alloc. - S.I.R. Management	1997	16,104	361	20	785	424	15,048	12
13	Alloc. - S.I.R. Management	1999	1,266		20	63	63	1,028	13
14	Alloc. - S.I.R. Management	1999	13,707		20			13,707	14
15	Alloc. - S.I.R. Management	2000	1,495		20	75	75	1,162	15
16	Alloc. - S.I.R. Management	2007	4,803		20	240	240	1,968	16
17	Alloc. - S.I.R. Management	2008	13,238	1,324	20	834	(490)	6,545	17
18	Alloc. - S.I.R. Management	2009	32,894	301	20	1,645	1,344	10,270	18
19	Alloc. - S.I.R. Management	2011	814	81	20	81		359	19
20	Alloc. - S.I.R. Management	2012	2,604	130	20	130		445	20
21	Alloc. - S.I.R. Management	2014	365	37	20	18	(19)	29	21
22									22
23	Alloc. - S.I.R. Properties - S.I.R. Management	2012	2,532	178	20	9	(169)	45	23
24	Alloc. - S.I.R. Properties - S.I.R. Management	2010	2,494		20	125	125	665	24
25	Alloc. - S.I.R. Properties - S.I.R. Management	2009	2,482	111	20	124	13	844	25
26	Alloc. - S.I.R. Properties - S.I.R. Management	2007	724	14	20	36	22	326	26
27	Alloc. - S.I.R. Properties - S.I.R. Management	2002	164		20	8	8	111	27
28	Alloc. - S.I.R. Properties - S.I.R. Management	1999	5,238		20	262	262	4,321	28
29	Alloc. - S.I.R. Properties - S.I.R. Management	1998	2,503		20	125	125	2,190	29
30	Alloc. - S.I.R. Properties - S.I.R. Management	1997	156		20	8	8	148	30
31	Alloc. - S.I.R. Properties - S.I.R. Management	1994	394	10	20		(10)	394	31
32	Alloc. - S.I.R. Properties - S.I.R. Management	1993	670	4	20		(4)	670	32
33									33
34	TOTAL (lines 1 thru 33)		$ 202,396	$ 5,326		$ 6,927	$ 1,601	$ 104,673	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: 01/01/15 Ending: 12/31/15

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		$ 202,396	$ 5,326		$ 6,927	$ 1,601	$ 104,673	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
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20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 202,396	$ 5,326		$ 6,927	$ 1,601	$ 104,673	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: 01/01/15 Ending: 12/31/15

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	$ 2,551,649	$ 65,049	$ 231,548	$ 166,499	10	$ 1,391,946	71
72	Current Year Purchases	26,814		2,238	2,238	10	2,239	72
73	Fully Depreciated Assets	696,651		6	6	10	696,651	73
74								74
75	TOTALS	$ 3,275,114	$ 65,049	$ 233,792	$ 168,743		$ 2,090,836	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	2015	$ 3,210	$ 280	$ 343	$ 63	5	$ 2,193	76
77										77
78										78
79										79
80	TOTALS			$ 3,210	$ 280	$ 343	$ 63		$ 2,193	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)	$ 20,237,089	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 582,501	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 801,246	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 218,745	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 11,118,649	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: 01/01/15 Ending: 12/31/15

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 7,375 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		$	$ 6,655	17
18					18
19					19
20					20
21	TOTAL		$	$ 6,655	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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 212,054	$		$ 212,054	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			232,290			232,290	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			382,939			382,939	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				309,456		309,456	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			918,879		159,136	465,852		1,543,867	13
14	TOTAL			$ 918,879		$ 986,419	$ 775,308		$ 2,680,606	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:** 01/01/15 **Ending:** 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/15 **(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	$ 38,582	$ 213,548	1
2	Cash-Patient Deposits	56,370	56,370	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,968,449	3,968,449	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	98,262	165,944	6
7	Other Prepaid Expenses	3,798	3,798	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		1,038,920	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,165,461	$ 5,447,029	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	1,097,674	4,453,431	15
16	Equipment, at Historical Cost	2,848,966	4,213,043	16
17	Accumulated Depreciation (book methods)	(2,696,966)	(10,550,352)	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	573,298	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,449,674	$ 9,991,920	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,615,135	$ 15,438,949	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 856,334	$ 856,335	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	56,370	56,370	28
29	Short-Term Notes Payable	2,650,000	2,650,000	29
30	Accrued Salaries Payable	446,285	446,285	30
31	Accrued Taxes Payable (excluding real estate taxes)	74,468	74,468	31
32	Accrued Real Estate Taxes(Sch.IX-B)		580,000	32
33	Accrued Interest Payable		44,166	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	79,453	79,453	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,162,910	$ 4,787,077	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		16,307,429	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)**	$	$ 16,307,429	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,162,910	$ 21,094,506	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,452,225	$ (5,655,557)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,615,135	$ 15,438,949	48

***(See instructions.)**

Facility Name & ID Number Elmwood Care **#** 0040410 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,255,385	1
2	Restatements (describe):		2
3	Rounding	(3)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,255,382	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	585,643	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	(388,800)	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)**	$ 196,843	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)**	$ 1,452,225	24 *

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 16,294,813	1
2	Discounts and Allowances for all Levels	(2,553,503)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,741,310	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,009,281	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,009,281	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	267,006	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	32,437	19
20	Radiology and X-Ray	12,993	20
21	Other Medical Services	814,458	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,126,894	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,851	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,851	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	550,324	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 550,324	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 18,435,660	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,161,125	31
32	Health Care	6,067,920	32
33	General Administration	4,164,848	33
	B. Capital Expense		
34	Ownership	2,193,873	34
	C. Ancillary Expense		
35	Special Cost Centers	2,759,621	35
36	Provider Participation Fee	502,630	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,850,017	40
41	**Income before Income Taxes (line 30 minus line 40)****	585,643	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 585,643	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 7,967,535	44
45	Private Pay - Net Inpatient Revenue	354,635	45
46	Medicare - Net Inpatient Revenue	867,702	46
47	Other-(specify) Veteran	84,752	47
48	Other-(specify) Hospice, Managed Care, Insurance	4,466,686	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 13,741,310	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: 01/01/15 Ending: 12/31/15

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	1,877	2,086	$ 132,675	$ 63.60	1
2	Assistant Director of Nursing	1,870	1,990	91,088	45.77	2
3	Registered Nurses	36,288	38,607	1,155,435	29.93	3
4	Licensed Practical Nurses	46,820	51,290	1,432,358	27.93	4
5	CNAs & Orderlies	110,404	117,081	1,316,723	11.25	5
6	CNA Trainees					6
7	Licensed Therapist	36,940	39,891	918,879	23.03	7
8	Rehab/Therapy Aides	13,650	15,496	294,644	19.01	8
9	Activity Director					9
10	Activity Assistants	8,041	9,066	102,699	11.33	10
11	Social Service Workers	11,521	12,312	189,096	15.36	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	30,251	33,852	383,594	11.33	15
16	Dishwashers					16
17	Maintenance Workers	5,605	5,864	80,474	13.72	17
18	Housekeepers	25,565	28,602	289,412	10.12	18
19	Laundry	11,042	12,240	119,581	9.77	19
20	Administrator	1,637	1,894	126,857	66.98	20
21	Assistant Administrator	1,869	2,086	74,141	35.54	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,592	22,445	278,990	12.43	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	7,350	8,749	265,267	30.32	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,353	2,474	80,615	32.58	33
34	TOTAL (lines 1 - 33)	373,675	406,025	$ 7,332,528 *	$ 18.06	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	$ 36,096	01-03	35
36	Medical Director	Monthly	39,080	09-03	36
37	Medical Records Consultant	Monthly	4,704	10-03	37
38	Nurse Consultant	Monthly	76,440	10-03	38
39	Pharmacist Consultant	Monthly	2,748	10-03	39
40	Physical Therapy Consultant	156	10,938	10a-03	40
41	Occupational Therapy Consultant	13	948	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	88	4,594	10a-03	43
44	Activity Consultant	Monthly	2,496	11-03	44
45	Social Service Consultant	Monthly	2,819	12-03	45
46	Other(specify) Dir. Of Food Service	Monthly	29,400	01-03	46
47	Specialized Rehab	Monthly	23,520	10a-03	47
48					48
49	TOTAL (lines 35 - 48)	257	$ 233,783		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: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Colleen Swanson	Administrator	0	$ 126,857
Barbara Dabrowski	Asst. Admin	0	74,141
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 200,998

B. Administrative - Other

Description	Amount
SIR Management - Director of Administrative Services	$ 70,560
SIR Management - Ancillary Administrative Charges	58,800
SIR Management - Consulting Fees	828,089
TOTAL (agree to Schedule V, line 17, col. 3)	$ 957,449
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FRR/Marcum LLP	Accounting Services	$ 19,760
Plante & Moran	Accounting Services	4,475
McGladrey/RSM	Accounting Services	1,455
SIR Management	Accounting Services	2,700
SIR Management	Dir. of Financial Services	48,000
SIR Management	Dir. of Regulatory Services	35,280
SIR Management	Bookkeeping Fees	120,540
PayChex	Payroll Systems	18,373
Legat Architect	Architecture Consulting	6,115
Achieve Accreditation	Accreditation	11,470
E-Health Data	Data Processing	3,300
See Supplemental Schedule		126,078
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 397,546

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 149,170
Unemployment Compensation Insurance	88,823
FICA Taxes	554,808
Employee Health Insurance	306,356
Employee Meals	47,830
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension Plan	45,030
401k Contribution	13,977
Other Employee Benefits	13,505
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,219,499

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	$ 1,992
Advertising: Employee Recruitment	2,182
Health Care Worker Background Check	
(Indicate # of checks performed 763.6)	7,636
Patient Background Checks	
Dues & Subcriptions	25,214
Licenses & Fees	3,696
Allocated from SIR Management	1,919
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 42,639

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,907
Allocated from SIR Management	1,392
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,299

**See instructions.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/15 Ending: 12/31/15

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:** 01/01/15 **Ending:** 12/31/15

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: $30,438**

(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. $ **23,369** 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. $ **499,267**
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. $ **47,830** 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.