

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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 Facility ID Number: 0040410

Facility Name: Elmwood Care

Address: 7733 West Grand Avenue Elmwood Park 60707
 Number City Zip Code

County: Cook

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

HFS ID Number: 363868389001

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

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____ (Date) _____

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) _____ (Date) _____

(Print Name and Title) Cary C. Buxbaum, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
 ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410 Report Period Beginning: 01/01/06 Ending: 12/31/06

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>49,339</u>	<u>3,691</u>	<u>14,992</u>	<u>68,022</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>49,339</u>	<u>3,691</u>	<u>14,992</u>	<u>68,022</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.07%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 04/01/93

J. Was the facility purchased or leased after January 1, 1978?

YES Date 04/01/93 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 245 and days of care provided 6,666

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	307,614	91,139	47,004	445,757		445,757	(23,584)	422,173			1
2	Food Purchase		335,815		335,815	(40,997)	294,818	(181)	294,637			2
3	Housekeeping	248,444	72,801		321,245		321,245	(2,729)	318,516			3
4	Laundry	89,911	44,012		133,923		133,923		133,923			4
5	Heat and Other Utilities			226,563	226,563		226,563	2,840	229,403			5
6	Maintenance	58,285	42,454	158,358	259,097		259,097	(36,858)	222,239			6
7	Other (specify):*							3,943	3,943			7
8	TOTAL General Services	704,254	586,221	431,925	1,722,400	(40,997)	1,681,403	(56,570)	1,624,834			8
	B. Health Care and Programs											
9	Medical Director			15,000	15,000		15,000		15,000			9
10	Nursing and Medical Records	2,906,402	344,164	331,708	3,582,274		3,582,274	(62,667)	3,519,607			10
10a	Therapy	79,649		72,910	152,559		152,559		152,559			10a
11	Activities	118,312	8,489	2,050	128,851		128,851		128,851			11
12	Social Services	104,142		1,607	105,749		105,749		105,749			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							3,620	3,620			15
16	TOTAL Health Care and Programs	3,208,505	352,653	423,275	3,984,433		3,984,433	(59,047)	3,925,386			16
	C. General Administration											
17	Administrative	174,885		90,288	265,173		265,173	(7,878)	257,295			17
18	Directors Fees											18
19	Professional Services			180,613	180,613		180,613	(133,791)	46,822			19
20	Dues, Fees, Subscriptions & Promotions			166,483	166,483		166,483	(40,762)	125,721			20
21	Clerical & General Office Expenses	100,111	47,845	467,342	615,298		615,298	(355,592)	259,706			21
22	Employee Benefits & Payroll Taxes			723,259	723,259	40,997	764,256	(2,212)	762,044			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,869	3,869		3,869	419	4,288			24
25	Other Admin. Staff Transportation			717	717		717	3,415	4,132			25
26	Insurance-Prop.Liab.Malpractice			180,400	180,400		180,400	(1,208)	179,192			26
27	Other (specify):*							25,549	25,549			27
28	TOTAL General Administration	274,996	47,845	1,812,971	2,135,812	40,997	2,176,809	(512,060)	1,664,749			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,187,755	986,719	2,668,171	7,842,645		7,842,645	(627,677)	7,214,968			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Elmwood Care

#0040410

Report Period Beginning:

01/01/06

Ending:

12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			138,348	138,348		138,348	309,128	447,476			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			205,610	205,610		205,610	760,704	966,314			32
33	Real Estate Taxes			422,033	422,033		422,033	14,287	436,320			33
34	Rent-Facility & Grounds			756,600	756,600		756,600	(756,600)				34
35	Rent-Equipment & Vehicles			6,764	6,764		6,764	3,296	10,060			35
36	Other (specify):*											36
37	TOTAL Ownership			1,529,355	1,529,355		1,529,355	330,815	1,860,170			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	336,880	570,832	573,035	1,480,747		1,480,747	(73,239)	1,407,508			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			134,138	134,138		134,138		134,138			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	336,880	570,832	707,173	1,614,885		1,614,885	(73,239)	1,541,646			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,524,635	1,557,551	4,904,699	10,986,885		10,986,885	(370,101)	10,616,784			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning: 01/01/06

Ending: 12/31/06

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	30,464	30		9
10	Interest and Other Investment Income	(247)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(181)	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	(3,150)	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	(419,185)	21		24
25	Fund Raising, Advertising and Promotional	(20,918)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(14,414)	20		28
29	Other-Attach Schedule	(65,431)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (493,062)		\$	30

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	2	
		Amount	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)	122,961		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 122,961		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (370,101)		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	2	3	4	
		Yes	No	Amount	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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
1 Misc Income	521	21	1
2 Prescription Drugs- Veterans	(11,751)	10	2
3 Purchased Services- Veterans	(521)	10	3
4 C/PE Fees	(3,053)	20	4
5 Non-Allowable Legal	(4,437)	19	5
6 PPA- Equipment Rental	(1,456)	35	6
7 PPA- Maintenance Supplies	(4,863)	06	7
8 Insurance Expense	(2,183)	25	8
9 Capitalized R & M	(17,698)	06	9
10 Amortization- Bldg. Co.	(19,388)	36	10
11			11
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98			98
99			99
100			100
101 Total	(65,431)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/06

Ending:

12/31/06

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					(17,508)	(6,076)						(23,584)	1
2	Food Purchase	(181)											(181)	2
3	Housekeeping			967					(3,696)				(2,729)	3
4	Laundry													4
5	Heat and Other Utilities			1,279	1,561								2,840	5
6	Maintenance	(22,561)		1,151	(13,537)		(2,530)				619		(36,858)	6
7	Other (specify):*				1,041	1,421	1,481						3,943	7
8	TOTAL General Services	(22,742)		3,397	(10,935)	(16,087)	(7,125)		(3,696)		619		(56,570)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(12,274)			(28,301)				(22,093)				(62,667)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				3,620								3,620	15
16	TOTAL Health Care and Programs	(12,274)			(24,681)				(22,093)				(59,047)	16
	C. General Administration													
17	Administrative			21,059	(74,548)	49,943	(4,320)				(12)		(7,878)	17
18	Directors Fees													18
19	Professional Services	(4,437)		(126,198)	289	16,403	(19,848)						(133,791)	19
20	Fees, Subscriptions & Promotions	(41,535)		339	434								(40,762)	20
21	Clerical & General Office Expenses	(419,237)		73,228	(9,583)								(355,592)	21
22	Employee Benefits & Payroll Taxes							(2,222)		10			(2,212)	22
23	Inservice Training & Education													23
24	Travel and Seminar			115	304								419	24
25	Other Admin. Staff Transportation			731	2,684								3,415	25
26	Insurance-Prop.Liab.Malpractice	(2,183)		403	572								(1,208)	26
27	Other (specify):*			13,219	4,097	8,233							25,549	27
28	TOTAL General Administration	(467,392)		(17,104)	(75,751)	74,579	(24,168)	(2,222)		(2)			(512,060)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(502,408)		(13,707)	(111,367)	58,492	(31,293)	(2,222)	(25,789)	(2)	619		(627,677)	29

STATE OF ILLINOIS

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/06 Ending:

Summary B

12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	30,464	257,442	2,069	11,040						8,113		309,128	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(247)	756,600	(662)	4,140						873		760,704	32
33	Real Estate Taxes		6,488	2,975	4,824								14,287	33
34	Rent-Facility & Grounds		(756,600)										(756,600)	34
35	Rent-Equipment & Vehicles	(1,486)		2,538	2,244								3,296	35
36	Other (specify):*	(19,385)	19,385											36
37	TOTAL Ownership	9,346	283,315	6,920	22,248						8,986		330,815	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(52,560)				(3,062)		(17,617)		(73,239)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers				(52,560)				(3,062)		(17,617)		(73,239)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(493,062)	283,315	(6,787)	(141,679)	58,492	(31,293)	(2,222)	(28,851)	(2)	(8,012)		(370,101)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Elmwood Care Bldg, LLC		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent Base	\$ 756,600	Elmwood Building, LLC	100.00%	\$	\$ (756,600)	1
2	V	33 Rent Taxes	422,033	Elmwood Building, LLC			(422,033)	2
3	V	36 Amortization		Elmwood Building, LLC		19,385	19,385	3
4	V	30 Depreciation		Elmwood Building, LLC		257,442	257,442	4
5	V	32 Mortgage		Elmwood Building, LLC		756,600	756,600	5
6	V	33 Real Estate Taxes		Elmwood Building, LLC		428,521	428,521	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,178,633			\$ 1,461,948	\$ * 283,315	14

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

Facility Name & ID Number Elmwood Care# 0040410Report Period Beginning: 01/01/06Ending: 12/31/06

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	3 HOUSEKEEPING	\$	PREFERRED BOOKKEEPING	100.00%	\$ 967	967	15
16	V	5 UTILITIES		PREFERRED BOOKKEEPING	100.00%	1,279	1,279	16
17	V	6 REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	1,151	1,151	17
18	V	17 ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	21,059	21,059	18
19	V	19 PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	1,372	1,372	19
20	V	20 DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	339	339	20
21	V	21 CLERICAL		PREFERRED BOOKKEEPING	100.00%	73,228	73,228	21
22	V	24 SEMINARS		PREFERRED BOOKKEEPING	100.00%	115	115	22
23	V	25 ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	731	731	23
24	V	26 INSURANCE		PREFERRED BOOKKEEPING	100.00%	403	403	24
25	V	27 EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	13,219	13,219	25
26	V	30 DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	2,069	2,069	26
27	V	32 INTEREST		PREFERRED BOOKKEEPING	100.00%	(662)	(662)	27
28	V	33 REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	2,975	2,975	28
29	V	35 EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	2,538	2,538	29
30	V							30
31	V							31
32	V	19 ACCOUNT./BOOKKEEPING	127,570	PREFERRED BOOKKEEPING	100.00%		(127,570)	32
33	V	19 COMPUTER	5,880	PREFERRED BOOKKEEPING	100.00%	5,880		33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 133,450			\$ 126,663	\$ * (6,787)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care# 0040410Report Period Beginning: 01/01/06Ending: 12/31/06

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5 UTILITIES	\$	S.I.R. MANAGEMENT, INC.	100.00%	\$ 1,561	1,561	15
16	V	6 REPAIRS AND MAINT.	22,056	S.I.R. MANAGEMENT, INC.	100.00%	8,519	(13,537)	16
17	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	1,041	1,041	17
18	V	10 NURSING	48,516	S.I.R. MANAGEMENT, INC.	100.00%	20,215	(28,301)	18
19	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	3,620	3,620	19
20	V	17 ADMINISTRATIVE	85,968	S.I.R. MANAGEMENT, INC.	100.00%	11,420	(74,548)	20
21	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	289	289	21
22	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	434	434	22
23	V	21 CLERICAL & GENERAL	24,996	S.I.R. MANAGEMENT, INC.	100.00%	15,413	(9,583)	23
24	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	304	304	24
25	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	2,684	2,684	25
26	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	572	572	26
27	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	4,097	4,097	27
28	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	2,294	2,294	28
29	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	520	520	29
30	V	33 REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	4,824	4,824	30
31	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	2,244	2,244	31
32	V							32
33	V	39 LEASED EQUIPMENT	52,560	S.I.R. MANAGEMENT, INC.	100.00%		(52,560)	33
34	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	8,746	8,746	34
35	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	3,620	3,620	35
36	V							36
37	V							37
38	V							38
39	Total		\$ 234,096			\$ 92,417	\$ * (141,679)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care# 0040410Report Period Beginning: 01/01/06Ending: 12/31/06

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1	DIETARY SALARIES	\$ 24,996	S.I.R. MANAGEMENT, INC.	100.00%	\$ 7,488	(17,508)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,421	1,421	16
17	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	49,943	49,943	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	16,403	16,403	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	8,233	8,233	19
20	V								20
21	V	17	ADMIN. SALARY-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			21
22	V	6	REPAIRS & MAINT.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			22
23	V	21	CLERICAL & GEN.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			23
24	V	26	AUTO INSURANCE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			24
25	V	27	EMP. BENEFITS-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			25
26	V	35	AUTO LEASE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			26
27	V								27
28	V	17	ADMIN. SALARY-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%			28
29	V	21	CLERICAL & GEN.-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%			29
30	V	26	AUTO INSURANCE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%			30
31	V	27	EMP. BENEFITS-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%			31
32	V	35	AUTO LEASE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%			32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 24,996				\$ 83,488	\$ * 58,492	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care# 0040410Report Period Beginning: 01/01/06Ending: 12/31/06

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	10A SPECIAL REHAB		S.I.R. MANAGEMENT, INC.	100.00%		\$	15	
16	V	15 EMP. BEN.-H. CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%			16	
17	V							17	
18	V	6 REPAIRS AND MAINT.	6,408	S.I.R. MANAGEMENT, INC.	100.00%	3,878	(2,530)	18	
19	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	736	736	19	
20	V							20	
21	V							21	
22	V	1 DIETICIAN SALARIES	10,000	S.I.R. MANAGEMENT, INC.	100.00%	3,924	(6,076)	22	
23	V	7 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	745	745	23	
24	V							24	
25	V	19 LEGAL FEES	19,848	S.I.R. MANAGEMENT, INC.	100.00%		(19,848)	25	
26	V							26	
27	V	17 COUNCIL DUES	4,320	S.I.R. MANAGEMENT, INC.	100.00%		(4,320)	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		\$ 40,576			\$ 9,283	\$ *	(31,293)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 109,727	\$ 109,727	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	111,949	CCS EMPLOYEE BENEFIT GROUP	100.00%		(111,949)	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			\$ 111,949			\$ 109,727	\$ * (2,222)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 DIETARY	\$	XCEL SUPPLY, LLC	100.00%	\$		15
16	V	03 HOUSEKEEPING	45,581	XCEL SUPPLY, LLC	100.00%	41,885	(3,696)	16
17	V	04 LAUNDRY		XCEL SUPPLY, LLC	100.00%			17
18	V	06 REPAIRS & MAINTENANCE		XCEL SUPPLY, LLC	100.00%			18
19	V	10 NURSING	272,421	XCEL SUPPLY, LLC	100.00%	250,328	(22,093)	19
20	V	11 ACTIVITIES		XCEL SUPPLY, LLC	100.00%			20
21	V	12 SOCIAL SERVICE		XCEL SUPPLY, LLC	100.00%			21
22	V	20 DUES, FEES, SUBSCRIPTIONS & PROM		XCEL SUPPLY, LLC	100.00%			22
23	V	21 CLERICAL & GENERAL OFFICE		XCEL SUPPLY, LLC	100.00%			23
24	V	22 EMPLOYEE BENEFITS		XCEL SUPPLY, LLC	100.00%			24
25	V	24 SEMINARS & EDUCATION		XCEL SUPPLY, LLC	100.00%			25
26	V	39 ANCILLARY	37,757	XCEL SUPPLY, LLC	100.00%	34,695	(3,062)	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		\$ 355,759			\$ 326,908	\$ * (28,851)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	22 HEALTH INSURANCE	\$ 16,380	ECM OWNERS COUNCIL	100.00%	\$ 16,234	\$ (146)	15	
16	V	17 ADMINISTRATOR SALARY	7,920	ECM OWNERS COUNCIL	100.00%	7,908	(12)	16	
17	V	22 PAYROLL TAXES	600	ECM OWNERS COUNCIL	100.00%	756	156	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		\$ 24,900			\$ 24,898	\$ *	(2)	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Repairs	\$	Vent Lease, LLC.	100.00%	\$ 619	\$ 619	15
16	V	30	Depreciation		Vent Lease, LLC.	100.00%	8,113	8,113	16
17	V	32	Interest		Vent Lease, LLC.	100.00%	873	873	17
18	V	39	Vent/Ancillary Reimbursement	17,617	Vent Lease, LLC.	100.00%		(17,617)	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			\$ 17,617			\$ 9,605	\$ * (8,012)	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/06 Ending: 12/31/06

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Relative	Administrative	0.00%	See Attached	0.77	1.67%	Alloc. Salary	\$ 10,433	17-7	1
2	Nenita Guzman	Relative	Dietary	0.00%	See Attached	5.47	10.94%	Alloc. Salary	7,488	1-7	2
3	Louise Bergthold	Shareholder	Administrative	4.90%	See Attached	6.02	10.95%	Alloc. Salary	18,046	17-7	3
4	Tom Winter	Shareholder	Administrative	1.43%	See Attached	7.66	12.77%	Alloc. Salary	21,059	17-7	4
5	Jeff Oravec	Shareholder	Administrative	0.41%	See Attached	4.37	10.93%	Alloc. Salary	11,352	17-7	5
6	Joey Abramchick	Shareholder	Administrative	2.04%	See Attached	4.92	10.93%	Alloc. Salary	16,403	17-7	6
7	Stuart Sikes	Shareholder	Administrative	0.82%	See Attached	4.37	10.93%	Alloc. Salary	11,643	17-7	7
8	Lori Barrish	Shareholder	Administrative	2.04%	None	40.00	100.00%	Sal./Alloc. Sal.	94,085	17-1, 17-7	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 190,509		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/06

Ending: 12/31/06

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/06

Ending: 12/31/06

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

Name of Related Organization PREFERRED BOOKKEEPING SERVICES
 Street Address 4100 WEST PRATT AVE.
 City / State / Zip Code LINCOLNWOOD, IL. 60712
 Phone Number (847) 674-5200
 Fax Number (847) 674-5267

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOME 999,524	10	\$ 7,576	\$	127,570	\$ 967	1
2	5	UTILITIES	BOOK./ACCNT.INCOME 999,524	10	10,021		127,570	1,279	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME 999,524	10	9,017		127,570	1,151	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME 999,524	10	165,000	165,000	127,570	21,059	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME 999,524	10	10,747		127,570	1,372	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME 999,524	10	2,655		127,570	339	6
7	21	CLERICAL	BOOK./ACCNT.INCOME 999,524	10	573,753	512,109	127,570	73,228	7
8	24	SEMINARS	BOOK./ACCNT.INCOME 999,524	10	898		127,570	115	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME 999,524	10	5,727		127,570	731	9
10	26	INSURANCE	BOOK./ACCNT.INCOME 999,524	10	3,157		127,570	403	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME 999,524	10	103,576		127,570	13,219	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME 999,524	10	16,212		127,570	2,069	12
13	32	INTEREST	BOOK./ACCNT.INCOME 999,524	10	(5,190)		127,570	(662)	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME 999,524	10	23,306		127,570	2,975	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME 999,524	10	19,888		127,570	2,538	15
16									16
17									17
18									18
19	19	COMPUTER	DIRECT ALLOCATION					5,880	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 946,343	\$ 677,109		\$ 126,663	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	UTILITIES	PATIENT DAYS	621,946	10	\$ 14,269	\$ 68,022	\$ 1,561	1	
2	6	REPAIRS AND MAINT.	PATIENT DAYS	621,946	10	77,891	51,158	68,022	8,519	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	621,946	10	9,520	68,022	1,041	3	
4	10	NURSING	PATIENT DAYS	621,946	10	184,832	184,832	68,022	20,215	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	621,946	10	33,100	68,022	3,620	5	
6	17	ADMINISTRATIVE	PATIENT DAYS	621,946	10	104,417	104,417	68,022	11,420	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	621,946	10	2,646	68,022	289	7	
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	621,946	10	3,970	68,022	434	8	
9	21	CLERICAL & GENERAL	PATIENT DAYS/DIRECT	621,946	10	163,095	125,172	68,022	15,413	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	621,946	10	2,778	68,022	304	10	
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	621,946	10	24,542	68,022	2,684	11	
12	26	INSURANCE	PATIENT DAYS	621,946	10	5,228	68,022	572	12	
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS/DIRECT	621,946	10	41,464	68,022	4,097	13	
14	30	DEPRECIATION	PATIENT DAYS	621,946	10	20,978	68,022	2,294	14	
15	32	INTEREST	PATIENT DAYS	621,946	10	4,752	68,022	520	15	
16	33	REAL ESTATE TAXES	PATIENT DAYS	621,946	10	44,103	68,022	4,824	16	
17	35	EQUIPMENT RENTAL	PATIENT DAYS	621,946	10	20,518	68,022	2,244	17	
18									18	
19	39	LEASED EQUIPMENT	LEASING INCOME	52,560	1		52,560		19	
20	30	DEPRECIATION	LEASING INCOME	52,560	1	8,746	52,560	8,746	20	
21	32	INTEREST	LEASING INCOME	52,560	1	3,620	52,560	3,620	21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 770,469	\$ 465,579	\$ 92,417	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY SALARIES	PATIENT DAYS	621,946	10	\$ 68,465	\$ 68,465	68,022	\$ 7,488	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	621,946	10	12,992		68,022	1,421	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	621,946	10	456,644	456,644	68,022	49,943	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	621,946	10	149,980		68,022	16,403	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	621,946	10	75,273		68,022	8,233	5
6										6
7	17	ADMIN. SALARY-B. BARRISH	AVG HRS WKD	20	4	15,163	15,163			7
8	6	REPAIRS & MAINT.-B. BARRIS	AVG HRS WKD	20	4	376				8
9	21	CLERICAL & GEN.-B. BARRIS	AVG HRS WKD	20	4	1,125				9
10	26	AUTO INSURANCE-B. BARRIS	AVG HRS WKD	20	4	330				10
11	27	EMP. BENEFITS-B. BARRISH	AVG HRS WKD	20	4	25,952				11
12	35	AUTO LEASE-B. BARRISH	AVG HRS WKD	20	4	5,250				12
13										13
14	17	ADMIN. SALARY-M. GIANNINI	AVG HRS WKD	30	4	9,863	9,863			14
15	21	CLERICAL & GEN.-M. GIANNI	AVG HRS WKD	30	4	375				15
16	26	AUTO INSURANCE-M. GIANNI	AVG HRS WKD	30	4	614				16
17	27	EMP. BENEFITS-M. GIANNINI	AVG HRS WKD	30	4	25,440				17
18	35	AUTO LEASE-M. GIANNINI	AVG HRS WKD	30	4	4,656				18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 852,498	\$ 550,135		\$ 83,488	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10A	SPECIAL REHAB	SPECIAL REHAB INC.	107,736	7	\$ 69,259	\$ 69,259		1
2	15	EMP. BEN.-H. CARE & PROG.	SPECIAL REHAB INC.	107,736	7	13,143			2
3									3
4	6	REPAIRS AND MAINT.	MAINTENANCE INC.	126,720	10	76,680	76,680	6,408	3,878
5	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	126,720	10	14,551	6,408	736	5
6									6
7									7
8	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	83,600	10	32,808	32,808	10,000	3,924
9	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	83,600	10	6,226	10,000	745	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					\$ 212,667	\$ 178,747		\$ 9,283

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CCS EMPLOYEE BENEFITS GROUP, INC.
 Street Address 2201 W. MAIN ST.
 City / State / Zip Code EVANSTON, IL 60202
 Phone Number (847)905-4000
 Fax Number (847)905-4040

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURANCE	DIRECT ALLOCATION		\$	\$		\$ 109,727	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				\$	\$		\$ 109,727	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

Name of Related Organization XCEL SUPPLY, LLC
 Street Address 2201 W. MAIN STREET
 City / State / Zip Code EVANSTON, IL 60202
 Phone Number (847)328-7600
 Fax Number (847)328-7615

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation		\$	\$		\$	1
2	03	HOUSEKEEPING	Direct Allocation					41,885	2
3	04	LAUNDRY	Direct Allocation						3
4	06	REPAIRS & MAINTENANCE	Direct Allocation						4
5	10	NURSING	Direct Allocation					250,328	5
6	11	ACTIVITIES	Direct Allocation						6
7	12	SOCIAL SERVICE	Direct Allocation						7
8	20	DUES, FEES, SUBSCRIPTIONS	Direct Allocation						8
9	21	CLERICAL & GENERAL OFFICE	Direct Allocation						9
10	22	EMPLOYEE BENEFITS	Direct Allocation						10
11	24	SEMINARS & EDUCATION	Direct Allocation						11
12	39	ANCILLARY	Direct Allocation					34,695	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				\$	\$		\$ 326,908	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/06

Ending: 12/31/06

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

Name of Related Organization ECM OWNERS COUNCIL
 Street Address 6840 N. LINCOLN
 City / State / Zip Code LINCOLNWOOD, IL 60646
 Phone Number (847)676-2026
 Fax Number ()

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	HEALTH INSURANCE	DIRECT ALLOCATION	4	\$	\$		16,234	1
2	17	ADMINISTRATOR SALARY	DIRECT ALLOCATION	4				7,908	2
3	22	PAYROLL TAXES	DIRECT ALLOCATION	4				756	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				\$	\$		24,898	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 Vent Lease, LLC
 Street Address 2201 W. Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 674-1180
 Fax Number (847) 673-7741

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	06	Repairs	Direct Billing	868,537	31	\$ 30,521	\$ 17,617	\$ 619	1
2	30	Depreciation	Direct Billing	868,537	31	400,000	17,617	8,113	2
3	32	Interest	Direct Billing	868,537	31	43,063	17,617	873	3
4	39	Vent/Ancillary Reimbursement							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					\$ 473,584	\$	\$ 9,605	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410 Report Period Beginning: 01/01/06 Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Interest on Capitalized Lease		X							\$ 756,600	1									
2	Alloc. Vent Lease, LLC		X							873	2									
3											3									
4											4									
5	See Supplemental Schedule										5									
Working Capital																				
6	Lake Forest Bank		X	Working Capital				3,825,000		Prime	205,610	6								
7											7									
8	See Supplemental Schedule									3,478	8									
9	TOTAL Facility Related							\$ 3,825,000			\$ 966,561	9								
B. Non-Facility Related*																				
10	Interest Income		X							(247)	10									
11											11									
12											12									
13	See Supplemental Schedule										13									
14	TOTAL Non-Facility Related										\$ (247)	14								
15	TOTALS (line 9+line14)							\$ 3,825,000			\$ 966,314	15								

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

* 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:

01/01/06

Ending:

12/31/06

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						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
6												6						
7	TOTAL Long-Term											7						
Working Capital																		
8	<u>Alloc. - Preferred Bookkeeping</u>		X				\$	\$			\$	<u>(662)</u>	8					
9	<u>Alloc. - S.I.R. Management</u>		X									<u>4,140</u>	9					
10												10						
11												11						
12												12						
13												13						
14	TOTAL Working Capital											<u>3,478</u>	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.)

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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 Bureau of Health Finance at (217) 782-1630.

2005 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 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>12-25-323-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>115,763.80</u>	\$ <u>115,763.80</u>
2. <u>12-25-323-004-0000</u>	<u>Long Term Care Property</u>	\$ <u>115,392.16</u>	\$ <u>115,392.16</u>
3. <u>12-25-323-005-000</u>	<u>Long Term Care Property</u>	\$ <u>180,607.99</u>	\$ <u>180,607.99</u>
4. <u>12-25-324-001-000</u>	<u>Long Term Care Property</u>	\$ <u>5,681.54</u>	\$ <u>5,681.54</u>
5. <u>12-25-324-002-000</u>	<u>Long Term Care Property</u>	\$ <u>5,875.12</u>	\$ <u>5,875.12</u>
6. <u>See Attached</u>	<u>See Attached</u>	\$ <u>89,494.10</u>	\$ <u>7,315.41</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>512,814.71</u>	\$ <u>430,636.02</u>

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 & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? 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:

01/01/06 Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,565 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 4

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

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

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

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

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

None

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	129,203		20	6,460	6,460	85,828	9
10	Various			1994	49,738		20	2,487	2,487	31,196	10
11	Various			1995	167,102		20	8,357	8,357	96,382	11
12	Various			1996	136,090		20	6,804	6,804	70,511	12
13	Various			1997	16,180		20	809	809	7,724	13
14	Various			1998	161,911		20	9,183	9,183	79,216	14
15	Various			1999	138,019		20	6,902	6,902	51,484	15
16	Various			2000	67,583		20	3,382	3,382	21,840	16
17	Various			2001	107,654		20	5,382	5,382	30,132	17
18	Various			2002	113,214		20	11,043	11,043	49,661	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

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Report Period Beginning:

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Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		10,419,509	257,442		297,700	40,258	3,677,849	67
68		96,555	3,269		3,808	539	43,767	68
69			138,348			(138,348)		69
70		\$ 11,602,758	\$ 399,059		\$ 362,317	\$ (36,742)	\$ 4,245,590	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/06

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12/31/06

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 11,602,758	\$ 399,059		\$ 362,317	\$ (36,742)	\$ 4,245,590	1
2	Boiler Work	2003	15,650		20	783	783	3,065	2
3	Boiler Valve	2003	2,576		20	129	129	504	3
4	Exhaust Work	2003	2,541		20	127	127	466	4
5	Electrical Work - Vent	2003	51,700		20	2,585	2,585	9,263	5
6	Vent Alarms (6)	2003	3,894		20	195	195	665	6
7	Vent Alarms (9)	2003	6,352		20	318	318	1,085	7
8	Kitchen Doors	2003	2,075		20	104	104	346	8
9	Exhaust Work	2003			20				9
10	Piping	2003	2,868		20	143	143	526	10
11	Walk In Freezer	2003	25,014		20	1,251	1,251	4,013	11
12	Vent- Alarm 4	2003	2,824		20	141	141	447	12
13	Vent Alarm-3	2003	2,117		20	106	106	344	13
14	Hvac Work	2003	3,329		20	166	166	527	14
15	Compressor & Condensor - Walk-In Freezer	2003	1,273		20	64	64	255	15
16	Boiler Extras	2003	1,097		20	55	55	215	16
17	Door Screens	2003	1,676		20	84	84	286	17
18	Replace Valves Kitchen Main Sink	2003	1,050		20	53	53	175	18
19	Cubicle Curtains	2003	3,173		20	159	159	516	19
20	Stair Treads	2003	1,046		20	52	52	161	20
21	Exterior Painting	2003	2,415		20	121	121	382	21
22	Repair Sewer & Drains	2003	1,360		20	68	68	249	22
23	Electrical Work	2004	9,956		20	498	498	1,493	23
24	Vent Wiring	2004	2,299		20	115	115	345	24
25	Vent Wiring	2004	4,496		20	225	225	674	25
26	Paint And Wallpaper	2004	50,465		20	2,523	2,523	7,359	26
27	Painting	2004	12,770		20	639	639	1,862	27
28	Painting	2004	12,124		20	606	606	1,768	28
29	Electrical Work	2004	5,510		20	276	276	804	29
30	Steel Door	2004	2,657		20	266	266	731	30
31	Steel Door	2004	2,932		20	293	293	806	31
32	Storage Tank	2004	2,240		20	112	112	308	32
33	Elevator Work	2004	2,045		20	102	102	273	33
34	TOTAL (lines 1 thru 33)		\$ 11,844,282	\$ 399,059		\$ 374,676	\$ (24,383)	\$ 4,285,503	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

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Ending:

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 11,844,282	\$ 399,059		\$ 374,676	\$ (24,383)	\$ 4,285,503	1
2	Paint & Wallpaper	2004	7,326		20	366	366	1,068	2
3	Hvac Compressor	2004	15,100		20	755	755	1,825	3
4	Water Pump	2004	1,320		20	66	66	149	4
5	Pump Repair	2004	1,048		20	105	105	288	5
6	Electrical Work	2004	1,429		20	71	71	155	6
7	Electrical Work	2004	2,080		20	104	104	217	7
8	Elevator Repair	2004	1,265		20	63	63	142	8
9	Electrical Work	2005	3,200		20	160	160	320	9
10	Elevator Work	2005	5,079		20	508	508	973	10
11	Door Locks	2005	4,175		20	418	418	731	11
12	Smoke Damper	2005	2,800		20	140	140	280	12
13	Door Locks	2005	4,120		20	206	206	412	13
14	Staircase Railing	2005	12,850		20	643	643	1,231	14
15	Elevator Work	2005	1,036		20	52	52	99	15
16	Water Pump	2005	2,256		20	113	113	216	16
17	Fire Doors	2005	16,800		20	840	840	1,540	17
18	Hvac Work	2005	2,469		20	123	123	226	18
19	Elevator Work	2005	4,805		20	240	240	400	19
20	Elevator Work	2005	3,473		20	174	174	260	20
21	Hvac Compressor	2005	3,944		20	197	197	296	21
22	Kitchen Door Kit	2005	737		20	74	74	92	22
23	Vertical Rod	2005	4,175		20	209	209	365	23
24	Railing	2005	12,200		20	610	610	1,169	24
25	Water Heater	2006	3,534		20	353	353	353	25
26	Flooring	2006	7,000		20	350	350	350	26
27	Electric Upgade	2006	7,159		20	179	179	179	27
28	Hvac Piping	2006	7,127		20	356	356	356	28
29	Fire System	2006	6,572		20	274	274	274	29
30	Water Pump	2006	2,534		20	95	95	95	30
31	Hvac Compressor	2006	4,404		20	92	92	92	31
32	Fire Door Work	2006	2,800		20	58	58	58	32
33	Elevator Repairs	2006	17,698		20	885	885	885	33
34	TOTAL (lines 1 thru 33)		\$ 12,016,797	\$ 399,059		\$ 383,555	\$ (15,504)	\$ 4,300,599	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 12,016,797	\$ 399,059		\$ 383,555	\$ (15,504)	\$ 4,300,599	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
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24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 12,016,797	\$ 399,059		\$ 383,555	\$ (15,504)	\$ 4,300,599	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Elmwood Care

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Report Period Beginning:

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Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 12,016,797	\$ 399,059		\$ 383,555	\$ (15,504)	\$ 4,300,599	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,016,797	\$ 399,059		\$ 383,555	\$ (15,504)	\$ 4,300,599	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Elmwood Care

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Report Period Beginning:

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12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 12,016,797	\$ 399,059		\$ 383,555	\$ (15,504)	\$ 4,300,599	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
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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)	\$ 12,016,797	\$ 399,059		\$ 383,555	\$ (15,504)	\$ 4,300,599	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 12,016,797	\$ 399,059		\$ 383,555	\$ (15,504)	\$ 4,300,599	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
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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)	\$ 12,016,797	\$ 399,059		\$ 383,555	\$ (15,504)	\$ 4,300,599	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 12,016,797	\$ 399,059		\$ 383,555	\$ (15,504)	\$ 4,300,599	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
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,016,797	\$ 399,059		\$ 383,555	\$ (15,504)	\$ 4,300,599	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 12,016,797	\$ 399,059		\$ 383,555	\$ (15,504)	\$ 4,300,599	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
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20								20
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24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 12,016,797	\$ 399,059		\$ 383,555	\$ (15,504)	\$ 4,300,599	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 12,016,797	\$ 399,059		\$ 383,555	\$ (15,504)	\$ 4,300,599	1
2									2
3									3
4									4
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6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,016,797	\$ 399,059		\$ 383,555	\$ (15,504)	\$ 4,300,599	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 12,016,797	\$ 399,059		\$ 383,555	\$ (15,504)	\$ 4,300,599	1
2									2
3									3
4									4
5									5
6									6
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,016,797	\$ 399,059		\$ 383,555	\$ (15,504)	\$ 4,300,599	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Elmwood Care

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Report Period Beginning:

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Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12K, Carried Forward		\$ 12,016,797	\$ 399,059		\$ 383,555	\$ (15,504)	\$ 4,300,599	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)		\$ 12,016,797	\$ 399,059		\$ 383,555	\$ (15,504)	\$ 4,300,599	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12L, Carried Forward		\$ 12,016,797	\$ 399,059		\$ 383,555	\$ (15,504)	\$ 4,300,599	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)		\$ 12,016,797	\$ 399,059		\$ 383,555	\$ (15,504)	\$ 4,300,599	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 12,016,797	\$ 399,059		\$ 383,555	\$ (15,504)	\$ 4,300,599	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)	\$ 12,016,797	\$ 399,059		\$ 383,555	\$ (15,504)	\$ 4,300,599	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12N, Carried Forward	\$ 12,016,797	\$ 399,059		\$ 383,555	\$ (15,504)	\$ 4,300,599		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)	\$ 12,016,797	\$ 399,059		\$ 383,555	\$ (15,504)	\$ 4,300,599		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 12,016,797	\$ 399,059		\$ 383,555	\$ (15,504)	\$ 4,300,599	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)	\$ 12,016,797	\$ 399,059		\$ 383,555	\$ (15,504)	\$ 4,300,599	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12P, Carried Forward		\$ 12,016,797	\$ 399,059		\$ 383,555	\$ (15,504)	\$ 4,300,599	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)		\$ 12,016,797	\$ 399,059		\$ 383,555	\$ (15,504)	\$ 4,300,599	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Elmwood Care

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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		1994	1975	\$ 10,419,509	\$ 257,442		\$ 297,700	\$ 40,258	\$ 3,677,849	4
5											5
6											6
7											7
8											8
Improvement Type**											
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											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Elmwood Care**

0040410

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	10,419,509	\$	257,442	\$	297,700	\$	40,258	\$	3,677,849	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Elmwood Care

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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	SIR - SIR		1993	1993	\$ 29,225	\$ 928	35	\$ 835	\$ (93)	\$ 11,272	4
5	SIR - PREF		1993	1993	18,022	572	35	515	(57)	6,951	5
6											6
7											7
8											8
	Improvement Type**										
9	Preferred Bookkeeping - Allocation			1997	22,507	504	20	1,125	621	11,038	9
10	Preferred Bookkeeping - Allocation			1999	179	-	20	9	9	67	10
11	Preferred Bookkeeping - Allocation			2000	1,129	-	20	56	56	362	11
12											
13	S.I.R. Properties - Preferred Bookkeeping - Allocation			2002	71	-	20	4	4	16	13
14	S.I.R. Properties - Preferred Bookkeeping - Allocation			1999	2,284	228	20	114	(114)	856	14
15	S.I.R. Properties - Preferred Bookkeeping - Allocation			1998	1,091	109	20	55	(54)	464	15
16	S.I.R. Properties - Preferred Bookkeeping - Allocation			1997	68	7	20	3	(4)	36	16
17	S.I.R. Properties - Preferred Bookkeeping - Allocation			1994	172	4	20	9	5	107	17
18	S.I.R. Properties - Preferred Bookkeeping - Allocation			1993	292	1	20	15	14	197	18
19											
20	S.I.R. Properties - S.I.R. Management - Allocation			2002	116	-	20	6	6	26	20
21	S.I.R. Properties - S.I.R. Management - Allocation			1999	3,703	370	20	185	(185)	1,389	21
22	S.I.R. Properties - S.I.R. Management - Allocation			1998	1,770	177	20	88	(89)	752	22
23	S.I.R. Properties - S.I.R. Management - Allocation			1997	110	11	20	6	(5)	58	23
24	S.I.R. Properties - S.I.R. Management - Allocation			1994	278	7	20	14	7	174	24
25	S.I.R. Properties - S.I.R. Management - Allocation			1993	474	2	20	24	22	320	25
26											
27	S.I.R. Management - Allocation			1993	12,552	349	20	622	273	8,712	27
28	S.I.R. Management - Allocation			1994	39	-	20	-		39	28
29	S.I.R. Management - Allocation			1995	287	-	20	14	14	164	29
30	S.I.R. Management - Allocation			1999	1,363	-	20	68	68	492	30
31	S.I.R. Management - Allocation			2000	823	-	20	41	41	275	31
32											
33											
34											
35											
36											

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Elmwood Care

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 96,555	\$ 3,269		\$ 3,808	\$ 539	\$ 43,767	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/06 Ending: 12/31/06

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 818,866	\$ 17,777	\$ 61,717	\$ 43,940	10	\$ 539,594	71
72	Current Year Purchases	66,846	174	2,202	2,028	10	2,202	72
73	Fully Depreciated Assets	998,507				10	998,507	73
74								74
75	TOTALS	\$ 1,884,219	\$ 17,951	\$ 63,919	\$ 45,968		\$ 1,540,303	75

D. Vehicle Depreciation (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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 14,626,007	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 417,010	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 447,474	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 30,464	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,840,902	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning: 01/01/06

Ending: 12/31/06

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

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 10,060

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	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	\$		\$ 157,265	\$		\$ 157,265	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			53,750			53,750	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			205,817			205,817	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 prescripts				287,497		287,497	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>See Supplemental</u>			336,880		156,203	283,335		776,418	13
14	TOTAL			\$ 336,880		\$ 573,035	\$ 570,832		\$ 1,480,747	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care# 0040410Report Period Beginning: 01/01/06

Ending:

12/31/06**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/06

(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	\$ 5,069	\$ 5,070	1
2	Cash-Patient Deposits	38,883	38,883	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	3,008,055	3,008,055	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		2,040	5
6	Prepaid Insurance	64,999	64,999	6
7	Other Prepaid Expenses	3,670	3,670	7
8	Accounts Receivable (owners or related parties)	4,000	4,000	8
9	Other(specify): <u>See Attached Schedule</u>	6,364	401,926	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,131,040	\$ 3,528,643	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		727,991	13
14	Buildings, at Historical Cost		10,419,509	14
15	Leasehold Improvements, at Historical Cost	565,974	565,974	15
16	Equipment, at Historical Cost	1,670,619	2,405,619	16
17	Accumulated Depreciation (book methods)	(1,601,642)	(5,933,975)	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): <u>See Attached Schedule</u>	598,222	646,682	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,233,173	\$ 8,831,800	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,364,213	\$ 12,360,443	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 460,169	\$ 460,169	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	40,444	40,444	28
29	Short-Term Notes Payable	3,825,000	3,825,000	29
30	Accrued Salaries Payable	236,409	236,409	30
31	Accrued Taxes Payable (excluding real estate taxes)	54,956	54,956	31
32	Accrued Real Estate Taxes(Sch.IX-B)		436,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,616,978	\$ 5,052,978	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>		11,882,500	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 11,882,500	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,616,978	\$ 16,935,478	46
47	TOTAL EQUITY(page 18, line 24)	\$ (252,765)	\$ (4,575,035)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,364,213	\$ 12,360,443	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 473,729	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 473,729	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(726,494)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (726,494)	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)	\$ (252,765)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care# 0040410Report Period Beginning: 01/01/06Ending: 12/31/06**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,570,518	1
2	Discounts and Allowances for all Levels	(287,152)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,283,366	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,136,840	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,136,840	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	273,563	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	30,706	19
20	Radiology and X-Ray	13,044	20
21	Other Medical Services	251,845	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 569,158	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	247	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 247	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	270,780	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 270,780	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,260,391	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,722,400	31
32	Health Care	3,984,433	32
33	General Administration	2,135,812	33
B. Capital Expense			
34	Ownership	1,529,355	34
C. Ancillary Expense			
35	Special Cost Centers	1,480,747	35
36	Provider Participation Fee	134,138	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,986,885	40
41	Income before Income Taxes (line 30 minus line 40)**	(726,494)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (726,494)	43

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

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

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

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

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,393	2,535	\$ 100,060	\$ 39.47	1
2	Assistant Director of Nursing	993	1,001	29,259	29.23	2
3	Registered Nurses	40,742	43,692	1,190,144	27.24	3
4	Licensed Practical Nurses	17,680	18,422	418,531	22.72	4
5	CNAs & Orderlies	92,077	97,126	969,596	9.98	5
6	CNA Trainees					6
7	Licensed Therapist	14,834	15,102	336,880	22.31	7
8	Rehab/Therapy Aides	6,759	7,098	79,649	11.22	8
9	Activity Director	2,931	3,420	49,440	14.46	9
10	Activity Assistants	8,783	9,142	68,872	7.53	10
11	Social Service Workers	9,715	10,309	104,142	10.10	11
12	Dietician					12
13	Food Service Supervisor	1,965	2,086	28,475	13.65	13
14	Head Cook	4,463	5,107	49,558	9.70	14
15	Cook Helpers/Assistants	22,513	24,174	229,581	9.50	15
16	Dishwashers					16
17	Maintenance Workers	4,535	4,697	58,285	12.41	17
18	Housekeepers	27,615	30,046	248,444	8.27	18
19	Laundry	10,856	11,356	89,911	7.92	19
20	Administrator	1,845	2,086	94,085	45.10	20
21	Assistant Administrator	3,933	4,262	80,800	18.96	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,828	12,081	100,111	8.29	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	9,932	10,883	198,812	18.27	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	296,392	314,625	\$ 4,524,635 *	\$ 14.38	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 22,008	01-03	35
36	Medical Director	Monthly	15,000	09-03	36
37	Medical Records Consultant	Monthly	4,224	10-03	37
38	Nurse Consultant	1,213	48,516	10-03	38
39	Pharmacist Consultant	Monthly	3,551	10-03	39
40	Physical Therapy Consultant	505	34,325	10a-03	40
41	Occupational Therapy Consultant	520	35,105	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	81	3,480	10a-03	43
44	Activity Consultant	Monthly	2,050	11-03	44
45	Social Service Consultant	31	1,607	12-03	45
46	Other(specify)				46
47	<u>Director of Food Service</u>	Monthly	24,996	01-03	47
48					48
49	TOTAL (lines 35 - 48)	2,350	\$ 194,862		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	237	\$ 9,276	10-03	50
51	Licensed Practical Nurses	7,861	266,141	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	8,098	\$ 275,417		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning: 01/01/06

Ending: 12/31/06

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Lori Barrish	Administrator	2.04	\$ 94,085	Workers' Compensation Insurance	\$ 82,411	IDPH License Fee	\$		
Caryl Kiser	Assist. Admin.	0	51,692	Unemployment Compensation Insurance	131,559	Advertising: Employee Recruitment	103,399		
Patrick Baalke	Admin. In Training	0	29,107	FICA Taxes	341,735	Health Care Worker Background Check			
				Employee Health Insurance	69,168	(Indicate # of checks performed <u>382</u>)	4,580		
				Employee Meals	40,997	Patient Background Checks <u>178</u>	2,140		
				Illinois Municipal Retirement Fund (IMRF)*		Advertising and Promotions	20,918		
				401K Plan	7,425	Licenses and Permits	3,751		
				Employee Benefits- Other	3,754	Yellow Page Advertising	14,414		
				Union Health and Welfare	84,995	IL Council Dues	8,259		
						See Supplemental Schedule	3,593		
						Less: Public Relations Expense	()		
						Non-allowable advertising	(20,918)		
						Yellow page advertising	(14,414)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)			
					\$ 174,884				
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			\$ 762,044		
Description				Amount					
Owners Council Dues				\$ 4,320					
S.I.R. - Administrative Charges - Ancillary & Dues				55,092					
S.I.R. - Management Fees- Dir of Administrative Services				30,876					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 90,288					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount		Description	Line #	Amount			
FR&R	Accounting	\$ 15,715				\$			
Preferred Bookkeeping	Accounting	30,550				Out-of-State Travel			
Preferred Bookkeeping	Bookkeeping	97,020							
Personel Planners	Unemployment Consult	2,016				In-State Travel			
LTC Solutions	Computer	1,320							
E-Health Data Solutions	MDS Software	3,789				Seminar Expense			
ICS Solutions	Website	38				3,869			
Preferred Bookkeeping	Computer	5,880				Alloc. - Preferred Bookkeeping			
Legal	Adj on 5A	4,437				115			
S.I.R. Management	Regulatory Services	19,848				Alloc. - S.I.R. Management			
						304			
						Entertainment Expense			
						()			
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL				TOTAL (agree to Sch. V, line 24, col. 8)	
				\$ 180,613				\$ 4,288	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

