

Facility Name & ID Number Elmwood Care

0040410 Report Period Beginning: 01/01/07 Ending: 12/31/07

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>54,149</u>	<u>3,582</u>	<u>12,051</u>	<u>69,782</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>54,149</u>	<u>3,582</u>	<u>12,051</u>	<u>69,782</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.03%

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: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/07 Ending: 12/31/07

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	301,825	108,660	44,966	455,451		455,451	(16,842)	438,609		1
2	Food Purchase		321,715		321,715	(38,435)	283,281	(165)	283,116		2
3	Housekeeping	262,629	72,799		335,428		335,428	(3,407)	332,021		3
4	Laundry	85,514	41,621		127,135		127,135		127,135		4
5	Heat and Other Utilities			230,158	230,158		230,158	(644)	229,514		5
6	Maintenance	66,472	30,549	167,999	265,020		265,020	(17,461)	247,559		6
7	Other (specify):*							3,039	3,039		7
8	TOTAL General Services	716,440	575,344	443,123	1,734,907	(38,435)	1,696,473	(35,479)	1,660,993		8
	B. Health Care and Programs										
9	Medical Director			14,400	14,400		14,400		14,400		9
10	Nursing and Medical Records	2,991,123	459,164	124,761	3,575,048		3,575,048	(56,862)	3,518,186		10
10a	Therapy	161,171		52,315	213,486		213,486		213,486		10a
11	Activities	136,789	10,644	2,352	149,785		149,785		149,785		11
12	Social Services	110,012		2,996	113,008		113,008		113,008		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							3,576	3,576		15
16	TOTAL Health Care and Programs	3,399,095	469,808	196,824	4,065,727		4,065,727	(53,286)	4,012,441		16
	C. General Administration										
17	Administrative	158,144		95,188	253,332		253,332	(651)	252,681		17
18	Directors Fees										18
19	Professional Services			235,567	235,567	(153)	235,414	(179,977)	55,437		19
20	Dues, Fees, Subscriptions & Promotions			68,290	68,290		68,290	(41,367)	26,923		20
21	Clerical & General Office Expenses	190,459	44,309	731,218	965,986		965,986	(611,188)	354,798		21
22	Employee Benefits & Payroll Taxes			777,266	777,266	38,435	815,701	(63)	815,638		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,583	1,583		1,583	338	1,921		24
25	Other Admin. Staff Transportation			1,467	1,467		1,467	5,170	6,637		25
26	Insurance-Prop.Liab.Malpractice			188,826	188,826		188,826	329	189,155		26
27	Other (specify):*							36,121	36,121		27
28	TOTAL General Administration	348,603	44,309	2,099,405	2,492,317	38,282	2,530,599	(791,288)	1,739,311		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,464,138	1,089,461	2,739,352	8,292,951	(153)	8,292,798	(880,053)	7,412,745		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: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			143,157	143,157		143,157	310,726	453,883		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			245,203	245,203		245,203	751,152	996,355		32
33	Real Estate Taxes			422,004	422,004	153	422,157	8,239	430,396		33
34	Rent-Facility & Grounds			1,062,850	1,062,850		1,062,850	(1,062,850)			34
35	Rent-Equipment & Vehicles			5,961	5,961		5,961	5,845	11,806		35
36	Other (specify):*										36
37	TOTAL Ownership			1,879,175	1,879,175	153	1,879,328	13,112	1,892,440		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers	527,735	914,890	884,999	2,327,624		2,327,624	(32,118)	2,295,506		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	527,735	914,890	1,019,137	2,461,762		2,461,762	(32,118)	2,429,644		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,991,873	2,004,351	5,637,664	12,633,888		12,633,888	(899,059)	11,734,829		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:

01/01/07

Ending:

12/31/07

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	38,060	30		9
10	Interest and Other Investment Income	(9,970)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(165)	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	(1,420)	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	(666,458)	21		24
25	Fund Raising, Advertising and Promotional	(26,740)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(13,170)	20		28
29	Other-Attach Schedule	(101,997)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (781,859)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	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)	(117,200)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (117,200)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (899,059)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Emwood Care ID# 0040416
 Report Period Beginning: 01/01/07
 Ending: 12/31/07

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
1 Theft & Damage	\$ (12,130)	21	1
2 Purchased Services - Veterans	(167)	10	2
3 Miscellaneous Income	(13,324)	21	3
4 Vein Supply Expense - Veteran	(396)	10	4
5 CAPP Dues	(2,670)	20	5
6 Amortization - Building Co.	(19,385)	36	6
7 Cable TV	(3,883)	08	7
8 Insurance Expense	(830)	29	8
9 Non-Allowable Legal Fees	(8,880)	19	9
10 PPA - S.I.R. Management Legal	(3,116)	19	10
11 Capitalized R&M	(6,028)	06	11
12			12
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14			14
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100			100
101 Total	(101,997)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/07

Ending:

12/31/07

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					(16,842)							(16,842)	1
2	Food Purchase	(165)											(165)	2
3	Housekeeping			997					(4,404)				(3,407)	3
4	Laundry													4
5	Heat and Other Utilities	(3,883)		1,579	1,660								(644)	5
6	Maintenance	(6,028)		1,386	(11,977)		(842)						(17,461)	6
7	Other (specify):*				1,060	1,629	350						3,039	7
8	TOTAL General Services	(10,076)		3,962	(9,257)	(15,213)	(492)		(4,404)				(35,479)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(563)			(29,979)				(26,320)				(56,862)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				3,576								3,576	15
16	TOTAL Health Care and Programs	(563)			(26,403)				(26,320)				(53,286)	16
	C. General Administration													
17	Administrative			23,582	(78,508)	58,607	(4,320)			(12)			(651)	17
18	Directors Fees													18
19	Professional Services	(41,196)		(136,612)	562	17,117	(19,848)						(179,977)	19
20	Fees, Subscriptions & Promotions	(44,000)		330	2,303								(41,367)	20
21	Clerical & General Office Expenses	(693,920)	(4)	78,008	4,635	93							(611,188)	21
22	Employee Benefits & Payroll Taxes									(63)			(63)	22
23	Inservice Training & Education													23
24	Travel and Seminar			31	307								338	24
25	Other Admin. Staff Transportation			1,164	4,006								5,170	25
26	Insurance-Prop.Liab.Malpractice	(810)		434	608	97							329	26
27	Other (specify):*			14,986	6,477	14,658							36,121	27
28	TOTAL General Administration	(779,926)	(4)	(18,077)	(59,610)	90,572	(24,168)			(75)			(791,288)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(790,565)	(4)	(14,115)	(95,270)	75,359	(24,660)		(30,723)	(75)			(880,053)	29

STATE OF ILLINOIS

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/07

Ending:

Summary B

12/31/07

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	38,060	257,442	1,984	13,240								310,726	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(9,970)	756,600	(77)	4,599								751,152	32
33	Real Estate Taxes		(787)	3,408	5,618								8,239	33
34	Rent-Facility & Grounds		(1,062,850)										(1,062,850)	34
35	Rent-Equipment & Vehicles			2,773	2,015	1,057							5,845	35
36	Other (specify):*	(19,385)	19,385											36
37	TOTAL Ownership	8,705	(30,210)	8,088	25,472	1,057							13,112	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(28,470)				(3,648)				(32,118)	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				(28,470)				(3,648)				(32,118)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(781,859)	(30,214)	(6,027)	(98,268)	76,416	(24,660)		(34,371)	(75)			(899,059)	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 Grand, 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 Grand, LLC	100.00%	\$	\$ (756,600)	1
2	V	34 Rent - Bonus	306,250	Elmwood Grand, LLC			(306,250)	2
3	V	33 Rent - Taxes	422,004	Elmwood Grand, LLC			(422,004)	3
4	V	36 Amort. - Assignment Fee		Elmwood Grand, LLC		12,718	12,718	4
5	V	36 Amort. - Intangibles		Elmwood Grand, LLC		6,667	6,667	5
6	V	30 Depr. - Base		Elmwood Grand, LLC		257,442	257,442	6
7	V	32 Mortgage - Interest Expense		Elmwood Grand, LLC		756,600	756,600	7
8	V	33 Real Estate Taxes		Elmwood Grand, LLC		421,217	421,217	8
9	V	21 Miscellaneous Income	4	Elmwood Grand, LLC			(4)	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,484,858			\$ 1,454,644	\$ * (30,214)	14

* 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: 01/01/07Ending: 12/31/07

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%	\$ 997	\$ 997	15
16	V	5 UTILITIES		PREFERRED BOOKKEEPING	100.00%	1,579	1,579	16
17	V	6 REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	1,386	1,386	17
18	V	17 ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	23,582	23,582	18
19	V	19 PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	1,123	1,123	19
20	V	20 DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	330	330	20
21	V	21 CLERICAL		PREFERRED BOOKKEEPING	100.00%	78,008	78,008	21
22	V	24 SEMINARS		PREFERRED BOOKKEEPING	100.00%	31	31	22
23	V	25 ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	1,164	1,164	23
24	V	26 INSURANCE		PREFERRED BOOKKEEPING	100.00%	434	434	24
25	V	27 EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	14,986	14,986	25
26	V	30 DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	1,984	1,984	26
27	V	32 INTEREST		PREFERRED BOOKKEEPING	100.00%	(77)	(77)	27
28	V	33 REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	3,408	3,408	28
29	V	35 EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	2,773	2,773	29
30	V							30
31	V							31
32	V	19 ACCOUNT./BOOKKEEPING	137,735	PREFERRED BOOKKEEPING	100.00%		(137,735)	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		\$ 143,615			\$ 137,588	\$ * (6,027)	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: 01/01/07Ending: 12/31/07

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%	\$ 1,660	\$ 1,660	15
16	V	6 REPAIRS AND MAINT.	22,056	S.I.R. MANAGEMENT, INC.	100.00%	10,079	(11,977)	16
17	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	1,060	1,060	17
18	V	10 NURSING	48,516	S.I.R. MANAGEMENT, INC.	100.00%	18,537	(29,979)	18
19	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	3,576	3,576	19
20	V	17 ADMINISTRATIVE	90,868	S.I.R. MANAGEMENT, INC.	100.00%	12,360	(78,508)	20
21	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	562	562	21
22	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	2,303	2,303	22
23	V	21 CLERICAL & GENERAL	24,996	S.I.R. MANAGEMENT, INC.	100.00%	29,631	4,635	23
24	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	307	307	24
25	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	4,006	4,006	25
26	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	608	608	26
27	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	6,477	6,477	27
28	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	4,873	4,873	28
29	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	3,394	3,394	29
30	V	33 REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	5,618	5,618	30
31	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	2,015	2,015	31
32	V							32
33	V	39 LEASED EQUIPMENT	28,470	S.I.R. MANAGEMENT, INC.	100.00%		(28,470)	33
34	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	8,367	8,367	34
35	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	1,205	1,205	35
36	V							36
37	V							37
38	V							38
39	Total		\$ 214,906			\$ 116,638	\$ * (98,268)	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: 01/01/07Ending: 12/31/07

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%	\$ 8,154	\$ (16,842)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,629	1,629	16
17	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	56,869	56,869	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	17,117	17,117	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	11,464	11,464	19
20	V								20
21	V	17	ADMIN. SALARY-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	1,211	1,211	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%	69	69	23
24	V	26	AUTO INSURANCE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	45	45	24
25	V	27	EMP. BENEFITS-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	1,620	1,620	25
26	V	35	AUTO LEASE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	614	614	26
27	V								27
28	V	17	ADMIN. SALARY-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	527	527	28
29	V	21	CLERICAL & GEN.-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	23	23	29
30	V	26	AUTO INSURANCE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	52	52	30
31	V	27	EMP. BENEFITS-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	1,574	1,574	31
32	V	35	AUTO LEASE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	443	443	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 24,996				\$ 101,412	\$ * 76,416	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	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.	2,592	S.I.R. MANAGEMENT, INC.	100.00%	1,750	(842)	18
19	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	350	350	19
20	V							20
21	V							21
22	V							22
23	V							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		\$ 26,760			\$ 2,100	\$ * (24,660)	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%	\$ 105,548	\$ 105,548	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	105,548	CCS EMPLOYEE BENEFIT GROUP	100.00%		(105,548)	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			\$ 105,548			\$ 105,548	\$ *	39

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

Facility Name & ID Number Elmwood Care# 0040410Report Period Beginning: 01/01/07Ending: 12/31/07

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	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	3 Housekeeping	54,603	Xcel Supply, LLC	100.00%	50,199	(4,404)	16
17	V	4 Laundry		Xcel Supply, LLC	100.00%			17
18	V	6 Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10 Nursing	326,340	Xcel Supply, LLC	100.00%	300,020	(26,320)	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 And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21 Office And Clerical		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	45,230	Xcel Supply, LLC	100.00%	41,582	(3,648)	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		\$ 426,172			\$ 391,801	\$ * (34,371)	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	\$ 18,680	ECM OWNERS COUNCIL	100.00%	\$ 18,469	\$ (211)	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%	748	148	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		\$ 27,200			\$ 27,125	\$ *	(75)	39

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

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning: 01/01/07

Ending: 12/31/07

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

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.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	Bryan Barrish	Relative	Administrative	14.13%	See Attached	1.27	3.18%	Alloc. Salary	\$ 1,211	17-7	1
2	Mike Giannini	Relative	Administrative	11.48%	See Attached	1.63	4.08%	Alloc. Salary	527	17-7	2
3	Eric Rothner	Relative	Administrative	0.00%	See Attached	0.80	1.73%	Alloc. Salary	11,072	17-7	3
4	Nenita Guzman	Relative	Dietary	0.00%	See Attached	5.71	11.42%	Alloc. Salary	8,154	1-7	4
5	Louise Bergthold	Shareholder	Administrative	4.90%	See Attached	6.28	11.42%	Alloc. Salary	20,543	17-7	5
6	Tom Winter	Shareholder	Administrative	1.43%	See Attached	7.86	13.10%	Alloc. Salary	23,582	17-7	6
7	Jeff Oravec	Shareholder	Administrative	0.41%	See Attached	4.57	11.43%	Alloc. Salary	14,113	17-7	7
8	Joey Abramchick	Shareholder	Administrative	2.04%	See Attached	5.14	9.35%	Alloc. Salary	17,117	17-7	8
9	Stuart Sikes	Shareholder	Administrative	0.82%	See Attached	4.57	11.43%	Alloc. Salary	12,713	17-7	9
10	Kim Rudolph	Relative	Clerical	0.00%	See Attached	0.57	1.63%	Alloc. Salary	500	22-7	10
11	Adam Vales	Relative	Clerical	2.85%	See Attached	0.65	1.63%	Alloc. Salary	908	22-7	11
12	Lori Barrish	Shareholder	Administrative	2.04%	None	55.00	100.00%	Sal./Alloc. Sal.	101,926	17-1, 17-7	12
13								TOTAL	\$ 212,366		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:

01/01/07

Ending: 12/31/07

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:

01/01/07

Ending: 12/31/07

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 1,051,322	10	\$ 7,611	\$	137,735	\$ 997	1
2	5	UTILITIES	BOOK./ACCNT.INCOME 1,051,322	10	12,056		137,735	1,579	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME 1,051,322	10	10,582		137,735	1,386	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME 1,051,322	10	180,000	180,000	137,735	23,582	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME 1,051,322	10	8,570		137,735	1,123	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME 1,051,322	10	2,521		137,735	330	6
7	21	CLERICAL	BOOK./ACCNT.INCOME 1,051,322	10	595,432	519,081	137,735	78,008	7
8	24	SEMINARS	BOOK./ACCNT.INCOME 1,051,322	10	240		137,735	31	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME 1,051,322	10	8,887		137,735	1,164	9
10	26	INSURANCE	BOOK./ACCNT.INCOME 1,051,322	10	3,314		137,735	434	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME 1,051,322	10	114,384		137,735	14,986	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME 1,051,322	10	15,147		137,735	1,984	12
13	32	INTEREST	BOOK./ACCNT.INCOME 1,051,322	10	(585)		137,735	(77)	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME 1,051,322	10	26,015		137,735	3,408	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME 1,051,322	10	21,168		137,735	2,773	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				\$ 1,005,342	\$ 699,081		\$ 137,588	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/07

Ending: 12/31/07

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	611,427	10	\$ 14,547	\$ 69,782	\$ 1,660	1	
2	6	REPAIRS AND MAINT.	PATIENT DAYS	611,427	10	88,312	52,015	69,782	10,079	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	611,427	10	9,289		69,782	1,060	3
4	10	NURSING	PATIENT DAYS	611,427	10	162,421	162,421	69,782	18,537	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	611,427	10	31,333		69,782	3,576	5
6	17	ADMINISTRATIVE	PATIENT DAYS	611,427	10	108,301	108,301	69,782	12,360	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	611,427	10	4,925		69,782	562	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	611,427	10	20,178		69,782	2,303	8
9	21	CLERICAL & GENERAL	PATIENT DAYS/DIRECT	611,427	10	259,625	203,511	69,782	29,631	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	611,427	10	2,693		69,782	307	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	611,427	10	35,101		69,782	4,006	11
12	26	INSURANCE	PATIENT DAYS	611,427	10	5,328		69,782	608	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS/DIRECT	611,427	10	56,748		69,782	6,477	13
14	30	DEPRECIATION	PATIENT DAYS	611,427	10	42,694		69,782	4,873	14
15	32	INTEREST	PATIENT DAYS	611,427	10	29,739		69,782	3,394	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	611,427	10	49,229		69,782	5,618	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	611,427	10	17,659		69,782	2,015	17
18										18
19	39	LEASED EQUIPMENT	LEASING INCOME	28,470	1			28,470		19
20	30	DEPRECIATION	LEASING INCOME	28,470	1	8,367		28,470	8,367	20
21	32	INTEREST	LEASING INCOME	28,470	1	1,205		28,470	1,205	21
22										22
23										23
24										24
25	TOTALS					\$ 947,694	\$ 526,247		\$ 116,638	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/07

Ending: 12/31/07

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	611,427	10	\$ 71,444	\$ 69,782	\$ 8,154	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	611,427	10	14,275	69,782	1,629	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	611,427	10	498,282	498,282	56,869	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	611,427	10	149,980	69,782	17,117	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	611,427	10	100,448	69,782	11,464	5
6									6
7	17	ADMIN. SALARY-B. BARRISH	AVG HRS WKD	23	10	22,231	22,231	1,211	7
8	6	REPAIRS & MAINT.-B. BARRIS	AVG HRS WKD	23	10		1		8
9	21	CLERICAL & GEN.-B. BARRIS	AVG HRS WKD	23	10	1,275	1	69	9
10	26	AUTO INSURANCE-B. BARRIS	AVG HRS WKD	23	10	824	1	45	10
11	27	EMP. BENEFITS-B. BARRISH	AVG HRS WKD	23	10	29,750	1	1,620	11
12	35	AUTO LEASE-B. BARRISH	AVG HRS WKD	23	10	11,272	1	614	12
13									13
14	17	ADMIN. SALARY-M. GIANNINI	AVG HRS WKD	30	10	9,702	9,702	527	14
15	21	CLERICAL & GEN.-M. GIANNI	AVG HRS WKD	30	10	425	2	23	15
16	26	AUTO INSURANCE-M. GIANNI	AVG HRS WKD	30	10	959	2	52	16
17	27	EMP. BENEFITS-M. GIANNINI	AVG HRS WKD	30	10	28,968	2	1,574	17
18	35	AUTO LEASE-M. GIANNINI	AVG HRS WKD	30	10	8,144	2	443	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 947,979	\$ 601,659	\$ 101,412	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	\$ 42,868	\$ 42,868		1
2	15	EMP. BEN.-H. CARE & PROG.	SPECIAL REHAB INC.	107,736	7	8,566			2
3									3
4	6	REPAIRS AND MAINT.	MAINTENANCE INC.	116,640	8	78,758	78,758	2,592	1,750
5	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	116,640	8	15,737		2,592	350
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					\$ 145,929	\$ 121,626		\$ 2,100

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 West Main Street
 City / State / Zip Code Evanston, IL 60202
 Phone Number (847)905-4000
 Fax Number (847)905-4040

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURANCE	DIRECT ALLOCATION		\$	\$		\$ 105,548	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				\$	\$		\$ 105,548	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 Xcel Supply, LLC
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, IL 60202
 Phone Number (847)328-7600
 Fax Number (847)328-7615

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	Direct Allocation			\$		\$	1	
2	3	Housekeeping	Direct Allocation					50,199	2	
3	4	Laundry	Direct Allocation						3	
4	6	Repairs & Maintenance	Direct Allocation						4	
5	10	Nursing	Direct Allocation					300,020	5	
6	11	Activities	Direct Allocation						6	
7	12	Social Service	Direct Allocation						7	
8	20	Dues, Fees And Subscriptions	Direct Allocation						8	
9	21	Office And Clerical	Direct Allocation						9	
10	22	Employee Benefits	Direct Allocation						10	
11	24	Seminars & Education	Direct Allocation						11	
12	39	Ancillary	Direct Allocation					41,582	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					\$		\$	391,801	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	\$	\$		18,469	1
2	17	ADMINISTRATOR SALARY	DIRECT ALLOCATION	4				7,908	2
3	22	PAYROLL TAXES	DIRECT ALLOCATION	4				748	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				\$	\$		27,125	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/07

Ending: 12/31/07

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

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/07

Ending: 12/31/07

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											2									
3											3									
4											4									
5	See Supplemental Schedule										5									
Working Capital																				
6	Lake Forest Bank		X	Working Capital				3,000,000		Prime	245,203	6								
7											7									
8	See Supplemental Schedule										4,522	8								
9	TOTAL Facility Related						\$	\$ 3,000,000			\$ 1,006,325	9								
B. Non-Facility Related*																				
10	Interest Income		X								(9,970)	10								
11												11								
12												12								
13	See Supplemental Schedule											13								
14	TOTAL Non-Facility Related						\$	\$			(9,970)	14								
15	TOTALS (line 9+line14)						\$	\$ 3,000,000			\$ 996,355	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:

01/01/07

Ending:

12/31/07

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

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

	1	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
A. Directly Facility Related																				
Long-Term																				
1							\$	\$			\$	1								
2												2								
3												3								
4												4								
5												5								
6												6								
7	TOTAL Long-Term											7								
Working Capital																				
8	Alloc. - Preferred Bookkeeping		X				\$	\$			\$ (77)	8								
9	Alloc. - S.I.R. Management		X								4,599	9								
10												10								
11												11								
12												12								
13												13								
14	TOTAL Working Capital										4,522	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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>12-25-324-001-0000</u>	<u>Long Term Care Property</u>	\$ <u>5,653.37</u>	\$ <u>5,653.37</u>
2. <u>12-25-324-002-0000</u>	<u>Long Term Care Property</u>	\$ <u>5,845.96</u>	\$ <u>5,845.96</u>
3. <u>12-25-323-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>115,188.46</u>	\$ <u>115,188.46</u>
4. <u>12-25-323-004-0000</u>	<u>Long Term Care Property</u>	\$ <u>114,818.73</u>	\$ <u>114,818.73</u>
5. <u>12-25-323-005-0000</u>	<u>Long Term Care Property</u>	\$ <u>179,710.39</u>	\$ <u>179,710.39</u>
6. <u>See Attached</u>	<u>See Attached</u>	\$ <u>94,525.44</u>	\$ <u>8,012.75</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>515,742.35</u>	\$ <u>429,229.66</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

01/01/07 Ending:

12/31/07

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>	<u>1</u>
2			<u>1998</u>	<u>100,000</u>	<u>2</u>
3	TOTALS			\$ 724,991	3

SEE ACCOUNTANTS' COMPILATION REPORT

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	92,285	9
10	Various		1994		49,738		20	2,487	2,487	33,680	10
11	Various		1995		167,102		20	8,357	8,357	104,735	11
12	Various		1996		136,090		20	6,804	6,804	77,316	12
13	Various		1997		16,180		20	809	809	8,532	13
14	Various		1998		161,911		20	9,183	9,183	88,396	14
15	Various		1999		138,019		20	6,902	6,902	58,383	15
16	Various		2000		67,583		20	3,382	3,382	25,217	16
17	Various		2001		107,654		20	5,382	5,382	35,513	17
18	Various		2002		113,214		20	11,043	11,043	60,700	18
19	Various		2003		134,030		20	6,704	6,704	30,192	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

0040410

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	3,975,549	67
68		106,837	3,989		4,042	53	49,373	68
69			143,157			(143,157)		69
70		\$ 11,747,070	\$ 404,588		\$ 369,255	\$ (35,333)	\$ 4,639,871	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:

01/01/07

Ending:

12/31/07

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		\$ 11,747,070	\$ 404,588		\$ 369,255	\$ (35,333)	\$ 4,639,871	1
2	Electrical Work	2004	9,956		20	498	498	1,991	2
3	Vent Wiring	2004	2,299		20	115	115	460	3
4	Vent Wiring	2004	4,496		20	225	225	899	4
5	Paint And Wallpaper	2004	50,465		20	2,523	2,523	9,883	5
6	Painting	2004	12,770		20	639	639	2,501	6
7	Painting	2004	12,124		20	606	606	2,374	7
8	Electrical Work	2004	5,510		20	276	276	1,079	8
9	Steel Door	2004	2,657		20	266	266	996	9
10	Steel Door	2004	2,932		20	293	293	1,100	10
11	Storage Tank	2004	2,240		20	112	112	420	11
12	Elevator Work	2004	2,045		20	102	102	375	12
13	Paint & Wallpaper	2004	7,326		20	366	366	1,435	13
14	Hvac Compressor	2004	15,100		20	755	755	2,580	14
15	Water Pump	2004	1,320		20	66	66	215	15
16	Pump Repair	2004	1,048		20	105	105	393	16
17	Electrical Work	2004	1,429		20	71	71	226	17
18	Electrical Work	2004	2,080		20	104	104	321	18
19	Elevator Repair	2004	1,265		20	63	63	206	19
20	Electrical Work	2005	3,200		20	160	160	480	20
21	Elevator Work	2005	5,079		20	508	508	1,481	21
22	Door Locks	2005	4,175		20	418	418	1,148	22
23	Smoke Damper	2005	2,800		20	140	140	420	23
24	Door Locks	2005	4,120		20	206	206	618	24
25	Staircase Railing	2005	12,850		20	643	643	1,874	25
26	Elevator Work	2005	1,036		20	52	52	151	26
27	Water Pump	2005	2,256		20	113	113	329	27
28	Fire Doors	2005	16,800		20	840	840	2,380	28
29	Hvac Work	2005	2,469		20	123	123	350	29
30	Elevator Work	2005	4,805		20	240	240	641	30
31	Elevator Work	2005	3,473		20	174	174	434	31
32	Hvac Compressor	2005	3,944		20	197	197	493	32
33	Kitchen Door Kit	2005	737		20	74	74	166	33
34	TOTAL (lines 1 thru 33)		\$ 11,951,876	\$ 404,588		\$ 380,328	\$ (24,260)	\$ 4,678,290	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	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		\$ 11,951,876	\$ 404,588		\$ 380,328	\$ (24,260)	\$ 4,678,290	1
2	Vertical Rod	2005	4,175		20	209	209	574	2
3	Railing	2005	12,200		20	610	610	1,779	3
4	Water Heater	2006	3,534		20	353	353	707	4
5	Flooring	2006	7,000		20	350	350	700	5
6	Electric Upgrade	2006	7,159		20	358	358	537	6
7	Hvac Piping	2006	7,127		20	713	713	1,069	7
8	Fire System	2006	6,572		20	329	329	602	8
9	Water Pump	2006	2,534		20	127	127	222	9
10	Hvac Compressor	2006	4,404		20	220	220	312	10
11	Fire Door Work	2006	2,800		20	140	140	198	11
12	Elevator Repairs	2006	17,698		20	885	885	1,549	12
13	Drapes	2007	5,309		20	531	531	531	13
14	Windows	2007	2,847		20	285	285	285	14
15	Pipe Insulation	2007	16,426		20	616	616	616	15
16	Pipe Insulation	2007	5,636		20	211	211	211	16
17	Exhaust Fans	2007	2,596		20	130	130	130	17
18	Boiler Work	2007	2,763		20	138	138	138	18
19	Concrete And Sewer	2007	2,200		20	92	92	92	19
20	Mixing Valves	2007	3,800		20	158	158	158	20
21	Cable/Phone Wire	2007	1,717		20	72	72	72	21
22	Cable/Phone Wire	2007	3,864		20	161	161	161	22
23	Fire Alarm System	2007	9,235		20	346	346	346	23
24	Low Pressure Alarms	2007	2,823		20	94	94	94	24
25	Hvac Work	2007	10,564		20	352	352	352	25
26	Ejector Pump	2007	1,563		20	52	52	52	26
27	Chemical Pump	2007	2,051		20	68	68	68	27
28	Electrical Work	2007	4,868		20	61	61	61	28
29	Flooring	2007	12,751		20	159	159	159	29
30	Low Air Loss Alarm	2007	7,058		20	176	176	176	30
31	Hot Water Valve	2007	2,188		20	55	55	55	31
32	Low Air Loss Alarm	2007	5,646		20	94	94	94	32
33	Boiler	2007	1,863		20	31	31	31	33
34	TOTAL (lines 1 thru 33)		\$ 12,134,847	\$ 404,588		\$ 388,504	\$ (16,084)	\$ 4,690,421	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 12,134,847	\$ 404,588		\$ 388,504	\$ (16,084)	\$ 4,690,421	1
2	Electrical Work	2007	3,877		20	16	16	16	2
3	Sewer Pump	2007	5,300		20	66	66	66	3
4	Fire Doors	2007	2,860		20	12	12	12	4
5	Fire Doors	2007	4,183		20	17	17	17	5
6	Basement Repiping	2007	68,859		20	3,443	3,443	3,443	6
7	Cubicle Curtains	2007	3,261		20	163	163	163	7
8	Alarm System	2007	2,767		20	138	138	138	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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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)		\$ 12,225,954	\$ 404,588		\$ 392,359	\$ (12,229)	\$ 4,694,276	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 12,225,954	\$ 404,588		\$ 392,359	\$ (12,229)	\$ 4,694,276	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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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)		\$ 12,225,954	\$ 404,588		\$ 392,359	\$ (12,229)	\$ 4,694,276	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:

01/01/07

Ending:

12/31/07

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 12E, Carried Forward		\$ 12,225,954	\$ 404,588		\$ 392,359	\$ (12,229)	\$ 4,694,276	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)		\$ 12,225,954	\$ 404,588		\$ 392,359	\$ (12,229)	\$ 4,694,276	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 12,225,954	\$ 404,588		\$ 392,359	\$ (12,229)	\$ 4,694,276	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
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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)		\$ 12,225,954	\$ 404,588		\$ 392,359	\$ (12,229)	\$ 4,694,276	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 12,225,954	\$ 404,588		\$ 392,359	\$ (12,229)	\$ 4,694,276	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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)		\$ 12,225,954	\$ 404,588		\$ 392,359	\$ (12,229)	\$ 4,694,276	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 12,225,954	\$ 404,588		\$ 392,359	\$ (12,229)	\$ 4,694,276	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)		\$ 12,225,954	\$ 404,588		\$ 392,359	\$ (12,229)	\$ 4,694,276	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 12,225,954	\$ 404,588		\$ 392,359	\$ (12,229)	\$ 4,694,276	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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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)		\$ 12,225,954	\$ 404,588		\$ 392,359	\$ (12,229)	\$ 4,694,276	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 12,225,954	\$ 404,588		\$ 392,359	\$ (12,229)	\$ 4,694,276	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,225,954	\$ 404,588		\$ 392,359	\$ (12,229)	\$ 4,694,276	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12K, Carried Forward		\$ 12,225,954	\$ 404,588		\$ 392,359	\$ (12,229)	\$ 4,694,276	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,225,954	\$ 404,588		\$ 392,359	\$ (12,229)	\$ 4,694,276	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12L, Carried Forward		\$ 12,225,954	\$ 404,588		\$ 392,359	\$ (12,229)	\$ 4,694,276	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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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)		\$ 12,225,954	\$ 404,588		\$ 392,359	\$ (12,229)	\$ 4,694,276	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12M, Carried Forward		\$ 12,225,954	\$ 404,588		\$ 392,359	\$ (12,229)	\$ 4,694,276	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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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,225,954	\$ 404,588		\$ 392,359	\$ (12,229)	\$ 4,694,276	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12N, Carried Forward		\$ 12,225,954	\$ 404,588		\$ 392,359	\$ (12,229)	\$ 4,694,276	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)		\$ 12,225,954	\$ 404,588		\$ 392,359	\$ (12,229)	\$ 4,694,276	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12O, Carried Forward		\$ 12,225,954	\$ 404,588		\$ 392,359	\$ (12,229)	\$ 4,694,276	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)		\$ 12,225,954	\$ 404,588		\$ 392,359	\$ (12,229)	\$ 4,694,276	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12P, Carried Forward		\$ 12,225,954	\$ 404,588		\$ 392,359	\$ (12,229)	\$ 4,694,276	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)		\$ 12,225,954	\$ 404,588		\$ 392,359	\$ (12,229)	\$ 4,694,276	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:

01/01/07

Ending:

12/31/07

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	\$ 3,975,549	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:

01/01/07

Ending:

12/31/07

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	\$	3,975,549	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	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	SIR - SIR		1993	1993	\$ 30,497	\$ 968	35	\$ 871	\$ (97)	\$ 12,634	4
5	SIR - Pref		1993	1993	18,499	587	35	529	(58)	7,664	5
6											6
7											7
8											8
	Improvement Type**										
9	Preferred Bookkeeping - Allocation		1997		23,103	517	20	1,155	638	12,486	9
10	Preferred Bookkeeping - Allocation		1999		183	-	20	9	9	78	10
11	Preferred Bookkeeping - Allocation		2000		1,159	-	20	58	58	430	11
12											12
13	S.I.R. Properties - Preferred Bookkeeping - Allocation		2007		324	16	20	16		16	13
14	S.I.R. Properties - Preferred Bookkeeping - Allocation		2002		73	-	20	4	4	20	14
15	S.I.R. Properties - Preferred Bookkeeping - Allocation		1999		2,344	234	20	117	(117)	996	15
16	S.I.R. Properties - Preferred Bookkeeping - Allocation		1998		1,120	112	20	56	(56)	532	16
17	S.I.R. Properties - Preferred Bookkeeping - Allocation		1997		70	3	20	3		40	17
18	S.I.R. Properties - Preferred Bookkeeping - Allocation		1994		176	5	20	9	4	119	18
19	S.I.R. Properties - Preferred Bookkeeping - Allocation		1993		300	2	20	15	13	218	19
20											20
21	S.I.R. Properties - S.I.R. Management - Allocation		2007		534	27	20	27		27	21
22	S.I.R. Properties - S.I.R. Management - Allocation		2002		121	-	20	6	6	33	22
23	S.I.R. Properties - S.I.R. Management - Allocation		1999		3,864	386	20	193	(193)	1,642	23
24	S.I.R. Properties - S.I.R. Management - Allocation		1998		1,847	185	20	92	(93)	877	24
25	S.I.R. Properties - S.I.R. Management - Allocation		1997		115	6	20	6		66	25
26	S.I.R. Properties - S.I.R. Management - Allocation		1994		290	7	20	15	8	196	26
27	S.I.R. Properties - S.I.R. Management - Allocation		1993		495	3	20	25	22	359	27
28											28
29	S.I.R. Management - Allocation		1993		13,098	365	20	649	284	9,741	29
30	S.I.R. Management - Allocation		1994		41	-	20	-		41	30
31	S.I.R. Management - Allocation		1995		299	-	20	15	15	186	31
32	S.I.R. Management - Allocation		1999		1,423	-	20	71	71	584	32
33	S.I.R. Management - Allocation		2000		859	-	20	43	43	330	33
34	S.I.R. Management - Allocation		2007		6,003	566	20	58	(508)	58	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:

01/01/07

Ending:

12/31/07

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)	\$	106,837	\$	3,989	\$	4,042	\$	53	\$	49,373	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: 01/01/07 Ending: 12/31/07

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	\$ 657,704	\$ 786	\$ 47,394	\$ 46,608	10	\$ 446,599	71
72	Current Year Purchases	154,022	10,448	14,129	3,681	10	5,339	72
73	Fully Depreciated Assets	1,097,411				10	1,097,411	73
74								74
75	TOTALS	\$ 1,909,137	\$ 11,234	\$ 61,523	\$ 50,289		\$ 1,549,349	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)	\$	14,860,082	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	415,822	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	453,882	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	38,060	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	6,243,625	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: 01/01/07

Ending: 12/31/07

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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 11,806

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		Contract	Total
		1 Drop-outs	2 Completed		
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	\$		\$ 256,105	\$		\$ 256,105	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			60,705			60,705	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			341,307			341,307	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				474,307		474,307	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>			527,735		226,882	440,583		1,195,200	13
14	TOTAL			\$ 527,735		\$ 884,999	\$ 914,890		\$ 2,327,624	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: 01/01/07

Ending:

12/31/07**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 4,611	\$ 4,616	1
2	Cash-Patient Deposits	68,085	68,085	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	3,110,550	3,110,550	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		2,040	5
6	Prepaid Insurance	71,894	71,894	6
7	Other Prepaid Expenses	2,135	2,135	7
8	Accounts Receivable (owners or related parties)	79,882	79,882	8
9	Other(specify): <u>See Attached Schedule</u>	190	396,539	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,337,347	\$ 3,735,741	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	678,392	678,392	15
16	Equipment, at Historical Cost	1,803,580	2,538,580	16
17	Accumulated Depreciation (book methods)	(1,744,799)	(6,334,574)	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>	357,051	692,376	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,094,224	\$ 8,722,274	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,431,571	\$ 12,458,015	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 874,710	\$ 874,710	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	68,912	68,912	28
29	Short-Term Notes Payable	3,000,000	3,000,000	29
30	Accrued Salaries Payable	280,241	280,241	30
31	Accrued Taxes Payable (excluding real estate taxes)	96,524	96,524	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)	\$ 4,320,387	\$ 4,756,387	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)	\$ 4,320,387	\$ 16,638,887	46
47	TOTAL EQUITY(page 18, line 24)	\$ 111,184	\$ (4,180,872)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,431,571	\$ 12,458,015	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (252,766)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (252,766)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	118,950	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) <u>Contributed Capital</u>	245,000	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 363,950	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)	\$ 111,184	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care# 0040410Report Period Beginning: 01/01/07Ending: 12/31/07**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	\$ 10,079,353	1
2	Discounts and Allowances for all Levels	(579,056)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,500,297	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,812,460	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,812,460	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	451,265	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	46,150	19
20	Radiology and X-Ray	26,865	20
21	Other Medical Services	509,031	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,033,311	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	9,971	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,971	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	396,799	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 396,799	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,752,838	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,734,907	31
32	Health Care	4,065,727	32
33	General Administration	2,492,317	33
B. Capital Expense			
34	Ownership	1,879,175	34
C. Ancillary Expense			
35	Special Cost Centers	2,327,624	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)*	\$ 12,633,888	40
41	Income before Income Taxes (line 30 minus line 40)**	118,950	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 118,950	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: 01/01/07

Ending:

12/31/07

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	2,703	2,824	\$ 112,628	\$ 39.88	1
2	Assistant Director of Nursing					2
3	Registered Nurses	40,094	41,978	1,203,274	28.66	3
4	Licensed Practical Nurses	17,235	17,973	433,715	24.13	4
5	CNAs & Orderlies	86,661	91,046	986,165	10.83	5
6	CNA Trainees					6
7	Licensed Therapist	24,033	24,573	527,735	21.48	7
8	Rehab/Therapy Aides	10,210	11,164	161,171	14.44	8
9	Activity Director	3,090	3,224	48,480	15.04	9
10	Activity Assistants	9,905	10,357	88,309	8.53	10
11	Social Service Workers	8,712	9,370	110,012	11.74	11
12	Dietician					12
13	Food Service Supervisor	1,917	2,086	29,401	14.09	13
14	Head Cook	3,571	3,984	39,633	9.95	14
15	Cook Helpers/Assistants	22,405	24,394	232,791	9.54	15
16	Dishwashers					16
17	Maintenance Workers	4,487	4,693	66,472	14.16	17
18	Housekeepers	28,664	30,928	262,629	8.49	18
19	Laundry	9,845	10,554	85,514	8.10	19
20	Administrator	1,751	2,086	101,938	48.87	20
21	Assistant Administrator	1,954	2,086	56,206	26.94	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,950	15,519	190,459	12.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	10,396	11,483	255,341	22.24	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	302,583	320,322	\$ 4,991,873 *	\$ 15.58	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	\$ 19,970	01-03	35
36	Medical Director	Monthly	14,400	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	3,659	10-03	39
40	Physical Therapy Consultant	378	25,705	10a-03	40
41	Occupational Therapy Consultant	347	23,430	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	74	3,180	10a-03	43
44	Activity Consultant	Monthly	2,352	11-03	44
45	Social Service Consultant	58	2,996	12-03	45
46	Other(specify)				46
47	<u>Director of Food Services</u>	Monthly	24,996	01-03	47
48					48
49	TOTAL (lines 35 - 48)	2,070	\$ 173,428		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	126	\$ 5,983	10-03	50
51	Licensed Practical Nurses	1,635	62,379	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,761	\$ 68,362		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning: 01/01/07

Ending: 12/31/07

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%	\$ 101,938	Workers' Compensation Insurance	\$ 124,371	IDPH License Fee	\$	
Caryl Kiser	Asst. Administrator	0%	56,206	Unemployment Compensation Insurance	96,265	Advertising: Employee Recruitment	4,892	
				FICA Taxes	371,953	Health Care Worker Background Check		
				Employee Health Insurance	72,496	(Indicate # of checks performed <u>421</u>)	5,050	
				Employee Meals	38,435	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Advertising & Promotion	26,740	
				401k Plan	8,050	Licenses & Permits	2,421	
				Employee Benefits - Other	2,052	Yellow page Advertising	13,170	
				Union Health and Welfare	102,016	IL Council on LTC Dues	8,642	
						See Supplemental Schedule	5,918	
						Less: Public Relations Expense	()	
						Non-allowable advertising	(26,740)	
						Yellow page advertising	(13,170)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
					\$ 815,638	\$ 26,923		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description				Description		Description		
Amount				Line #		Amount		
Owners Council Dues						Out-of-State Travel		
\$ 4,320						\$		
SIR Management - Dir. Of Administrative Services								
35,776								
SIR Management - Ancillary Administrative Charges						In-State Travel		
55,092								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL		Seminar Expense		
\$ 95,188						1,583		
						Alloc. - Preferred Bookkeeping		
						31		
						Alloc. - S.I.R. Management		
						307		
						Entertainment Expense		
						()		
						(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)						\$ 1,921		
\$ 235,567								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number Elmwood Care

Report Period Beginning: 01/01/07 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
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16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council - \$11,312, IHCF - \$3,185
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,333 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 134,138
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 38,435 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT