

Facility Name & ID Number Elmwood Care

0040410 Report Period Beginning: 01/01/08 Ending: 12/31/08

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>89,670</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>89,670</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>57,243</u>	<u>2,437</u>	<u>9,160</u>	<u>68,840</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>57,243</u>	<u>2,437</u>	<u>9,160</u>	<u>68,840</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.77%

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 7,733

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: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	324,557	97,076	49,980	471,613		471,613	(20,125)	451,488			1
2	Food Purchase		323,604		323,604	(39,111)	284,493	(114)	284,379			2
3	Housekeeping	282,452	81,243		363,695		363,695	(2,531)	361,164			3
4	Laundry	76,269	63,243		139,512		139,512	(18)	139,494			4
5	Heat and Other Utilities			258,312	258,312		258,312	(2,373)	255,939			5
6	Maintenance	92,598	28,585	227,992	349,175		349,175	(61,793)	287,382			6
7	Other (specify):*							4,995	4,995			7
8	TOTAL General Services	775,876	593,751	536,284	1,905,911	(39,111)	1,866,800	(81,958)	1,784,842			8
	B. Health Care and Programs											
9	Medical Director			14,100	14,100		14,100		14,100			9
10	Nursing and Medical Records	3,197,540	562,485	411,077	4,171,102		4,171,102	(57,575)	4,113,527			10
10a	Therapy	259,395		42,917	302,312		302,312	(22,554)	279,758			10a
11	Activities	132,623	6,885	2,423	141,931		141,931		141,931			11
12	Social Services	128,134		4,233	132,367		132,367		132,367			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							3,690	3,690			15
16	TOTAL Health Care and Programs	3,717,692	569,370	474,750	4,761,812		4,761,812	(76,438)	4,685,374			16
	C. General Administration											
17	Administrative	177,880		120,552	298,432		298,432	(6,919)	291,513			17
18	Directors Fees											18
19	Professional Services			289,459	289,459	(2,500)	286,959	(160,824)	126,135			19
20	Dues, Fees, Subscriptions & Promotions			93,681	93,681		93,681	(43,308)	50,373			20
21	Clerical & General Office Expenses	134,280	47,094	252,969	434,343		434,343	(129,541)	304,802			21
22	Employee Benefits & Payroll Taxes			846,984	846,984	39,111	886,095	12	886,107			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,301	5,301		5,301	(27)	5,274			24
25	Other Admin. Staff Transportation			5,014	5,014		5,014	8,826	13,840			25
26	Insurance-Prop.Liab.Malpractice			212,698	212,698		212,698	964	213,662			26
27	Other (specify):*							39,278	39,278			27
28	TOTAL General Administration	312,160	47,094	1,826,658	2,185,912	36,611	2,222,523	(291,539)	1,930,984			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,805,728	1,210,215	2,837,692	8,853,635	(2,500)	8,851,135	(449,935)	8,401,200			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: 01/01/08 Ending: 12/31/08

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			136,811	136,811		136,811	472,690	609,501		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			197,084	197,084		197,084	761,774	958,858		32
33	Real Estate Taxes			421,553	421,553	2,500	424,053	107,180	531,233		33
34	Rent-Facility & Grounds			1,188,215	1,188,215		1,188,215	(1,188,215)			34
35	Rent-Equipment & Vehicles			8,050	8,050		8,050	7,088	15,138		35
36	Other (specify):*										36
37	TOTAL Ownership			1,951,713	1,951,713	2,500	1,954,213	160,517	2,114,730		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers	778,815	920,665	1,026,393	2,725,873		2,725,873	(42,031)	2,683,842		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			134,506	134,506		134,506		134,506		42
43	Other (specify):*	60,388			60,388		60,388	(60,388)			43
44	TOTAL Special Cost Centers	839,203	920,665	1,160,899	2,920,767		2,920,767	(102,419)	2,818,348		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,644,931	2,130,880	5,950,304	13,726,115		13,726,115	(391,837)	13,334,278		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: 01/01/08

Ending: 12/31/08

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	(4,832)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	138,160	30		9
10	Interest and Other Investment Income	(394)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(114)	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	(320)	21		19
20	Contributions	(3,276)	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	(163,884)	21		24
25	Fund Raising, Advertising and Promotional	(22,778)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(10,084)	20		28
29	Other-Attach Schedule	(190,526)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (258,048)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(133,789)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (133,789)		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (391,837)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Elmwood Care

ID# 0040410

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Vent Supply- Veteran	\$ (254)	10	1
2	Purchased Services- Veteran	(504)	10	2
3	Theft/Loss	247	21	3
4	Misc Income	(21,768)	21	4
5	Collections	(681)	20	5
6	Capitalized R&M	(43,228)	06	6
7	COPE Dues	(8,260)	20	7
8	Marketing Salaries	(60,388)	43	8
9	Non-Allowable Seminar	(578)	24	9
10	Amortization- Building Company	(19,385)	36	10
11	Office Expense- Building Company	(110)	21	11
12	Professional Fees- Building Company	(6,250)	19	12
13	Non-Allowable Legal	(29,367)	19	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
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(190,526)		49

Elmwood Care

ID# 0040410

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
50	\$		1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(20,125)								(20,125)	1
2	Food Purchase	(114)											(114)	2
3	Housekeeping					(2,531)							(2,531)	3
4	Laundry					(18)							(18)	4
5	Heat and Other Utilities	(4,832)		2,459									(2,373)	5
6	Maintenance	(43,228)		(14,311)	(4,254)								(61,793)	6
7	Other (specify):*			856	4,139								4,995	7
8	TOTAL General Services	(48,174)		(10,996)	(20,239)	(2,549)							(81,958)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(758)		(42,519)	7,552	(21,850)							(57,575)	10
10a	Therapy				(22,554)								(22,554)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			1,750	1,940								3,690	15
16	TOTAL Health Care and Programs	(758)		(40,769)	(13,061)	(21,850)							(76,438)	16
	C. General Administration													
17	Administrative			(107,316)	100,405			(8)					(6,919)	17
18	Directors Fees													18
19	Professional Services	(35,617)	6,250	(145,920)	14,463								(160,824)	19
20	Fees, Subscriptions & Promotions	(45,079)		1,771									(43,308)	20
21	Clerical & General Office Expenses	(185,835)	110	51,320	4,864								(129,541)	21
22	Employee Benefits & Payroll Taxes							12					12	22
23	Inservice Training & Education													23
24	Travel and Seminar	(578)		551									(27)	24
25	Other Admin. Staff Transportation			8,826									8,826	25
26	Insurance-Prop.Liab.Malpractice			964									964	26
27	Other (specify):*			17,235	22,043								39,278	27
28	TOTAL General Administration	(267,109)	6,360	(172,569)	141,775			4					(291,539)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(316,041)	6,360	(224,334)	108,475	(24,398)		4					(449,935)	29

STATE OF ILLINOIS

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/08

Ending:

Summary B

12/31/08

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	138,160	291,839	42,691									472,690	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(394)	756,600	5,568									761,774	32
33	Real Estate Taxes		101,116	6,064									107,180	33
34	Rent-Facility & Grounds		(1,188,215)										(1,188,215)	34
35	Rent-Equipment & Vehicles			7,088									7,088	35
36	Other (specify):*	(19,385)	19,385											36
37	TOTAL Ownership	118,381	(19,275)	61,411									160,517	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers			(24,000)		(18,031)							(42,031)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(60,388)											(60,388)	43
44	TOTAL Special Cost Centers	(60,388)		(24,000)		(18,031)							(102,419)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(258,048)	(12,915)	(186,923)	108,475	(42,430)			4				(391,837)	45

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/08

Ending:

12/31/08

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 & Bonus	\$ 1,188,215	Elmwood Grand, LLC	100.00%	\$	\$ (1,188,215)	1
2	V	33 Rent- Taxes	421,553	Elmwood Grand, LLC	100.00%		(421,553)	2
3	V	36 Amortization- Assign. Fee		Elmwood Grand, LLC	100.00%	12,718	12,718	3
4	V	36 Amortization- Intangibles		Elmwood Grand, LLC	100.00%	6,667	6,667	4
5	V	30 Depreciation		Elmwood Grand, LLC	100.00%	291,839	291,839	5
6	V	32 Interest		Elmwood Grand, LLC	100.00%	756,600	756,600	6
7	V	21 Office Expense		Elmwood Grand, LLC	100.00%	110	110	7
8	V	19 Professional Fees		Elmwood Grand, LLC	100.00%	6,250	6,250	8
9	V	33 Real Estate Taxes		Elmwood Grand, LLC	100.00%	522,669	522,669	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,609,768			\$ 1,596,853	\$ * (12,915)	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: 01/01/08Ending: 12/31/08

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%	\$ 2,459	\$ 2,459	15
16	V	6 REPAIRS AND MAINT.	26,460	S.I.R. MANAGEMENT, INC.	100.00%	12,149	(14,311)	16
17	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	856	856	17
18	V	10 NURSING	52,920	S.I.R. MANAGEMENT, INC.	100.00%	10,401	(42,519)	18
19	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	1,750	1,750	19
20	V	17 ADMINISTRATIVE	107,316	S.I.R. MANAGEMENT, INC.	100.00%		(107,316)	20
21	V	19 PROFESSIONAL FEES	165,348	S.I.R. MANAGEMENT, INC.	100.00%	19,428	(145,920)	21
22	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	1,771	1,771	22
23	V	21 CLERICAL & GENERAL	52,920	S.I.R. MANAGEMENT, INC.	100.00%	104,240	51,320	23
24	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	551	551	24
25	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	8,826	8,826	25
26	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	964	964	26
27	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	17,235	17,235	27
28	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	12,336	12,336	28
29	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	5,568	5,568	29
30	V	33 REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	6,064	6,064	30
31	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	7,088	7,088	31
32	V							32
33	V	39 LEASED EQUIPMENT	24,000	S.I.R. MANAGEMENT, INC.	100.00%		(24,000)	33
34	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	30,355	30,355	34
35	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%			35
36	V							36
37	V							37
38	V							38
39	Total		\$ 428,964			\$ 242,041	\$ * (186,923)	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: 01/01/08Ending: 12/31/08

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	\$ 26,460	S.I.R. MANAGEMENT, INC.	100.00%	\$ 6,335	\$ (20,125)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,036	1,036	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	7,552	7,552	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	1,198	1,198	18
19	V	17	ADMIN./LEGAL SALARIES	13,236	S.I.R. MANAGEMENT, INC.	100.00%	113,641	100,405	19
20	V	21	CLERICAL & OFFICE SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	4,864	4,864	20
21	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	14,463	14,463	21
22	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	22,043	22,043	22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	26,460	S.I.R. MANAGEMENT, INC.	100.00%	3,906	(22,554)	24
25	V	15	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	742	742	25
26	V								26
27	V	6	MAINTENANCE SALARIES	19,120	S.I.R. MANAGEMENT, INC.	100.00%	14,866	(4,254)	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	3,103	3,103	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		\$ 85,276				\$ 193,750	\$ * 108,475	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	1 Dietary	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	3 Housekeeping	28,572	Xcel Supply, LLC	100.00%	26,041	(2,531)	16
17	V	4 Laundry	200	Xcel Supply, LLC	100.00%	183	(18)	17
18	V	6 Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10 Nursing	246,675	Xcel Supply, LLC	100.00%	224,825	(21,850)	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	203,566	Xcel Supply, LLC	100.00%	185,534	(18,031)	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		\$ 479,013			\$ 436,583	\$ * (42,430)	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 100,192	\$ 100,192	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	100,192	CCS Employee Benefits Group	100.00%		(100,192)	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			\$ 100,192			\$ 100,192	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 HEALTH INSURANCE	\$ 13,920	ECM OWNERS COUNCIL	100.00%	\$ 13,843	\$ (77)	15
16	V	17 ADMINISTRATOR SALARY	5,280	ECM OWNERS COUNCIL	100.00%	5,272	(8)	16
17	V	22 PAYROLL TAXES	400	ECM OWNERS COUNCIL	100.00%	489	89	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		\$ 19,600			\$ 19,604	\$ *	4 39

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning: 01/01/08

Ending: 12/31/08

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: 01/01/08 Ending: 12/31/08

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	2.55	6.38%	Alloc. Salary	\$ 16,579	17-7	1
2	Mike Giannini	Relative	Administrative	11.48%	See Attached	2.98	7.45%	Alloc. Salary	16,579	17-7	2
3	Eric Rothner	Relative	Administrative	0.00%	See Attached	0.60	1.30%	Alloc. Salary	9,350	17-7	3
4	Nenita Guzman	Relative	Dietary	0.00%	See Attached	4.25	8.50%	Alloc. Salary	6,335	1-7	4
5	Louise Bergthold	Shareholder	Administrative	4.90%	See Attached	4.68	8.51%	Alloc. Salary	16,579	17-7	5
6	Tom Winter	Shareholder	Administrative	1.43%	See Attached	5.10	8.50%	Alloc. Salary	16,579	17-7	6
7	Jeff Oravec	Shareholder	Administrative	0.41%	See Attached	3.40	8.50%	Alloc. Salary	10,488	17-7	7
8	Joey Abramchick	Shareholder	Administrative	2.04%	See Attached	3.83	8.51%	Alloc. Salary	14,463	17-7	8
9	Kim Rudolph	Relative	Clerical	0.00%	See Attached	0.32	1.92%	Alloc. Salary	280	22-7	9
10	Adam Vales	Relative	Clerical	2.85%	See Attached	0.77	1.93%	Alloc. Salary	1,379	22-7	10
11	Lori Barrish	Shareholder	Administrative	2.04%	See Attached	34.56	62.84%	Alloc. Salary	62,285	17-1, 17-7	11
12	Sarah Barrish	Relative	Administrative	0.00%	See Attached	5.53	100.00%	Alloc. Salary	1,222	17-7	12
13								TOTAL	\$ 172,118		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: 01/01/08

Ending: 12/31/08

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: 01/01/08

Ending: 12/31/08

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	809,665	13	\$ 28,924	\$ 68,840	\$ 2,459	1	
2	6	REPAIRS AND MAINT.	PATIENT DAYS	809,665	13	142,892	61,135	68,840	12,149	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	809,665	13	10,063	68,840	856	3	
4	10	NURSING	PATIENT DAYS	809,665	13	122,335	122,335	68,840	10,401	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	809,665	13	20,583	68,840	1,750	5	
6	17	ADMINISTRATIVE	PATIENT DAYS	809,665	13		68,840		6	
7	19	PROFESSIONAL FEES	PATIENT DAYS	809,665	13	228,501	152,688	68,840	19,428	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	809,665	13	20,828	68,840	1,771	8	
9	21	CLERICAL & GENERAL	PATIENT DAYS	809,665	13	1,226,029	1,066,051	68,840	104,240	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	809,665	13	6,483	68,840	551	10	
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	809,665	13	103,811	68,840	8,826	11	
12	26	INSURANCE	PATIENT DAYS	809,665	13	11,341	68,840	964	12	
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	809,665	13	202,715	68,840	17,235	13	
14	30	DEPRECIATION	PATIENT DAYS	809,665	13	145,092	68,840	12,336	14	
15	32	INTEREST	PATIENT DAYS	809,665	13	65,487	68,840	5,568	15	
16	33	REAL ESTATE TAXES	PATIENT DAYS	809,665	13	71,319	68,840	6,064	16	
17	35	EQUIPMENT RENTAL	PATIENT DAYS	809,665	13	83,368	68,840	7,088	17	
18									18	
19	39	LEASED EQUIPMENT	LEASING INCOME	24,000	1		24,000		19	
20	30	DEPRECIATION	LEASING INCOME	24,000	1	30,355	24,000	30,355	20	
21	32	INTEREST	LEASING INCOME	24,000	1		24,000		21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 2,520,126	\$ 1,402,210	\$ 242,041	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/08

Ending: 12/31/08

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 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

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	DIETARY SALARIES	PATIENT DAYS	809,665	13	\$ 74,508	\$ 74,508	68,840	\$ 6,335	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	809,665	13	12,182		68,840	1,036	2
3	10	NURSING SALARIES	PATIENT DAYS	809,665	13	88,823	88,823	68,840	7,552	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	809,665	13	14,090		68,840	1,198	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	809,665	13	1,336,598	1,336,598	68,840	113,641	5
6	21	CLERICAL & OFFICE SALARIES	PATIENT DAYS	809,665	13	57,211	57,211	68,840	4,864	6
7	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	809,665	13	170,103		68,840	14,463	7
8	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	809,665	13	259,260		68,840	22,043	8
9										9
10	10A	DIRECTOR OF SPECIAL REHAB	SPECIAL REHAB INC.	268,263	13	39,604	39,604	26,460	3,906	10
11	15	EMPLOYEE BENEFITS	SPECIAL REHAB INC.	268,263	13	7,528		26,460	742	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	153,288	9	119,187	119,187	19,120	14,866	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	153,288	9	24,879		19,120	3,103	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,203,973	\$ 1,715,931		\$ 193,750	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning: 01/01/08

Ending: 12/31/08

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					26,041	2
3	4	Laundry	Direct Allocation					183	3
4	6	Repairs & Maintenance	Direct Allocation						4
5	10	Nursing	Direct Allocation					224,825	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					185,534	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				\$	\$		\$ 436,583	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning: 01/01/08

Ending: 12/31/08

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 100,192	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				\$	\$		\$ 100,192	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/08

Ending: 12/31/08

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	\$	\$		13,843	1
2	17	ADMINISTRATOR SALARY	DIRECT ALLOCATION	4				5,272	2
3	22	PAYROLL TAXES	DIRECT ALLOCATION	4				489	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				\$	\$		19,604	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/08

Ending: 12/31/08

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: 01/01/08 Ending: 12/31/08

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:

01/01/08

Ending: 12/31/08

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:

01/01/08

Ending: 12/31/08

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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Notes Payable		X				\$	2,624,758			\$	756,600	1
2													2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	SIR Management	X		Line of Credit				3,612,691				197,084	6
7	Partners	X		Loans Payable				1,480,000					7
8	See Supplemental Schedule											5,568	8
9	TOTAL Facility Related						\$	7,717,449			\$	959,252	9
	B. Non-Facility Related*												
10	Interest Income		X									(394)	10
11													11
12													12
13	See Supplemental Schedule												13
14	TOTAL Non-Facility Related						\$				\$	(394)	14
15	TOTALS (line 9+line14)						\$	7,717,449			\$	958,858	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/08

Ending:

12/31/08

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																			
	Working Capital																			
8	Alloc. - S.I.R. Management		X				\$	\$			\$	5,568								
9												9								
10												10								
11												11								
12												12								
13												13								
14	TOTAL Working Capital																			
	B. Non-Facility Related*																			
15							\$	\$			\$	15								
16												16								
17												17								
18												18								
19												19								
20	TOTAL Non-Facility Related																			

* 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.)

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2007 report.		\$ 436,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 474,733	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 38,733	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 490,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$ 2,500	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$ _____	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 531,233	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	428,669	8
	2004	418,245	9
	2005	423,320	10
	2006	421,217	11
	2007	468,669	12
2007 Accrual = \$474,733 x 1.03 = \$490,000			
Allocation - SIR Management \$6,064			
FOR BHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2007 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>12-25-324-001-0000</u>	<u>Long Term Care Property</u>	\$ <u>5,300.45</u>	\$ <u>5,300.45</u>
2. <u>12-25-324-002-0000</u>	<u>Long Term Care Property</u>	\$ <u>5,394.66</u>	\$ <u>5,394.66</u>
3. <u>12-25-323-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>128,540.62</u>	\$ <u>128,540.62</u>
4. <u>12-25-323-004-0000</u>	<u>Long Term Care Property</u>	\$ <u>128,416.26</u>	\$ <u>128,416.26</u>
5. <u>12-25-323-005-0000</u>	<u>Long Term Care Property</u>	\$ <u>201,017.01</u>	\$ <u>201,017.01</u>
6. <u>See Attached</u>	<u>See Attached</u>	\$ <u>101,615.67</u>	\$ <u>6,214.50</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>570,284.67</u>	\$ <u>474,883.50</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:** 2007 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 2007 real estate tax costs, as well as copies of your real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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	\$ <u>_____</u>	\$ <u>_____</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? 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:

01/01/08 Ending:

12/31/08

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	98,746	9
10	Various			1994	49,738		20	2,487	2,487	36,167	10
11	Various			1995	167,102		20	8,357	8,357	113,089	11
12	Various			1996	136,090		20	6,804	6,804	84,119	12
13	Various			1997	16,180		20	809	809	9,342	13
14	Various			1998	158,155		20	7,786	7,786	95,309	14
15	Various			1999	121,088		20	6,056	6,056	57,714	15
16	Various			2000	67,583		20	3,382	3,382	28,597	16
17	Various			2001	107,654		20	5,382	5,382	40,897	17
18	Various			2002	113,214		20	11,043	11,043	71,743	18
19	Various			2003	145,109		20	7,812	7,812	42,527	19
20	Various			2004	124,757		20	5,954	5,954	29,614	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:

01/01/08

Ending:

12/31/08

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		12,291,591	291,839		391,304	99,465	4,366,853	67
68		101,849	3,251		3,686	435	52,328	68
69			136,811			(136,811)		69
70		\$ 13,729,313	\$ 431,901		\$ 467,322	\$ 35,421	\$ 5,127,045	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:

01/01/08

Ending:

12/31/08

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		\$ 13,729,313	\$ 431,901		\$ 467,322	\$ 35,421	\$ 5,127,045	1
2	Electrical Work	2005	3,200		20	160	160	640	2
3	Elevator Work	2005	5,079		20	508	508	1,989	3
4	Door Locks	2005	4,175		20	418	418	1,566	4
5	Smoke Damper	2005	2,800		20	140	140	560	5
6	Door Locks	2005	4,120		20	206	206	824	6
7	Staircase Railing	2005	12,850		20	643	643	2,516	7
8	Elevator Work	2005	1,036		20	52	52	203	8
9	Water Pump	2005	2,256		20	113	113	442	9
10	Fire Doors	2005	16,800		20	840	840	3,220	10
11	Hvac Work	2005	2,469		20	123	123	473	11
12	Elevator Work	2005	4,805		20	240	240	881	12
13	Elevator Work	2005	3,473		20	174	174	608	13
14	Hvac Compressor	2005	3,944		20	197	197	690	14
15	Kitchen Door Kit	2005	737		20	74	74	240	15
16	Vertical Rod	2005	4,175		20	209	209	783	16
17	Railing	2005	12,200		20	610	610	2,389	17
18	Water Heater	2006	3,534		20	353	353	1,060	18
19	Flooring	2006	7,000		20	350	350	1,050	19
20	Electric Upgrade	2006	7,159		20	358	358	895	20
21	Hvac Piping	2006	7,127		20	713	713	1,782	21
22	Fire System	2006	6,572		20	329	329	931	22
23	Water Pump	2006	2,534		20	127	127	348	23
24	Hvac Compressor	2006	4,404		20	220	220	532	24
25	Fire Door Work	2006	2,800		20	140	140	338	25
26	Elevator Repairs	2006	17,698		20	885	885	2,433	26
27	Basement Repiping	2006	68,859		20	3,443	3,443	7,173	27
28	Drapes	2007	5,309		20	531	531	1,062	28
29	Windows	2007	2,847		20	285	285	569	29
30	Pipe Insulation	2007	16,426		20	821	821	1,437	30
31	Pipe Insulation	2007	5,636		20	282	282	493	31
32	Exhaust Fans	2007	2,596		20	260	260	389	32
33	Boiler Work	2007	2,763		20	138	138	276	33
34	TOTAL (lines 1 thru 33)		\$ 13,976,696	\$ 431,901		\$ 481,264	\$ 49,363	\$ 5,165,837	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:

01/01/08

Ending:

12/31/08

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		\$ 13,976,696	\$ 431,901		\$ 481,264	\$ 49,363	\$ 5,165,837	1
2	Concrete And Sewer	2007	2,200		20	110	110	202	2
3	Mixing Valves	2007	3,800		20	190	190	348	3
4	Cable/Phone Wire	2007	1,717		20	86	86	157	4
5	Cable/Phone Wire	2007	3,864		20	193	193	354	5
6	Fire Alarm System	2007	9,235		20	462	462	808	6
7	Low Pressure Alarms	2007	2,823		20	141	141	235	7
8	Hvac Work	2007	10,564		20	528	528	880	8
9	Ejector Pump	2007	1,563		20	156	156	208	9
10	Chemical Pump	2007	2,051		20	205	205	273	10
11	Electrical Work	2007	4,868		20	243	243	304	11
12	Flooring	2007	12,751		20	638	638	797	12
13	Low Air Loss Alarm	2007	7,058		20	706	706	882	13
14	Hot Water Valve	2007	2,188		20	219	219	274	14
15	Low Air Loss Alarm	2007	5,646		20	565	565	659	15
16	Boiler	2007	1,863		20	186	186	217	16
17	Electrical Work	2007	3,877		20	194	194	210	17
18	Sewer Pump	2007	5,300		20	265	265	331	18
19	Fire Doors	2007	2,860		20	143	143	155	19
20	Fire Doors	2007	4,183		20	209	209	227	20
21	2008 Audit Adjustment 2007	2007	(12,836)		20	(1,284)	(1,284)	(1,391)	21
22	Cubicle Curtains	2007	3,261		20	163	163	299	22
23	Alarm System	2007	2,767		20	138	138	208	23
24	Boiler Work	2008	10,825		20	1,083	1,083	1,083	24
25	Fire Door	2008	2,460		20	62	62	62	25
26	Curtains	2008	10,230		20	512	512	512	26
27	Flooring- Vinyl Rock/Gridstone Tiles	2008	3,320		20	166	166	166	27
28	Surveillance System	2008	3,424		20	171	171	171	28
29	Flooring- Vynl	2008	4,400		20	220	220	220	29
30	Ejector Pumps/Piping	2008	5,323		20	266	266	266	30
31	Return Pump, Boiler, 7 Exhaust	2008	2,909		20	145	145	145	31
32	Sprinkler System	2008	6,566		20	328	328	328	32
33	Elevator Tracks	2008	7,056		20	353	353	353	33
34	TOTAL (lines 1 thru 33)		\$ 14,114,812	\$ 431,901		\$ 489,027	\$ 57,126	\$ 5,175,781	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:

01/01/08

Ending:

12/31/08

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		\$ 14,114,812	\$ 431,901		\$ 489,027	\$ 57,126	\$ 5,175,781	1
2									2
3									3
4									4
5									5
6									6
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 14,114,812	\$ 431,901		\$ 489,027	\$ 57,126	\$ 5,175,781	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:

01/01/08

Ending:

12/31/08

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		\$ 14,114,812	\$ 431,901		\$ 489,027	\$ 57,126	\$ 5,175,781	1
2									2
3									3
4									4
5									5
6									6
7									7
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 14,114,812	\$ 431,901		\$ 489,027	\$ 57,126	\$ 5,175,781	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:

01/01/08

Ending:

12/31/08

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 12E, Carried Forward		\$ 14,114,812	\$ 431,901		\$ 489,027	\$ 57,126	\$ 5,175,781	1
2									2
3									3
4									4
5									5
6									6
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 14,114,812	\$ 431,901		\$ 489,027	\$ 57,126	\$ 5,175,781	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:

01/01/08

Ending:

12/31/08

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		\$ 14,114,812	\$ 431,901		\$ 489,027	\$ 57,126	\$ 5,175,781	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 14,114,812	\$ 431,901		\$ 489,027	\$ 57,126	\$ 5,175,781	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:

01/01/08

Ending:

12/31/08

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		\$ 14,114,812	\$ 431,901		\$ 489,027	\$ 57,126	\$ 5,175,781	1
2									2
3									3
4									4
5									5
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 14,114,812	\$ 431,901		\$ 489,027	\$ 57,126	\$ 5,175,781	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:

01/01/08

Ending:

12/31/08

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		\$ 14,114,812	\$ 431,901		\$ 489,027	\$ 57,126	\$ 5,175,781	1
2									2
3									3
4									4
5									5
6									6
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 14,114,812	\$ 431,901		\$ 489,027	\$ 57,126	\$ 5,175,781	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:

01/01/08

Ending:

12/31/08

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		\$ 14,114,812	\$ 431,901		\$ 489,027	\$ 57,126	\$ 5,175,781	1
2									2
3									3
4									4
5									5
6									6
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 14,114,812	\$ 431,901		\$ 489,027	\$ 57,126	\$ 5,175,781	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:

01/01/08

Ending:

12/31/08

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		\$ 14,114,812	\$ 431,901		\$ 489,027	\$ 57,126	\$ 5,175,781	1
2									2
3									3
4									4
5									5
6									6
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 14,114,812	\$ 431,901		\$ 489,027	\$ 57,126	\$ 5,175,781	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:

01/01/08

Ending:

12/31/08

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		\$ 14,114,812	\$ 431,901		\$ 489,027	\$ 57,126	\$ 5,175,781	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)		\$ 14,114,812	\$ 431,901		\$ 489,027	\$ 57,126	\$ 5,175,781	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:

01/01/08

Ending:

12/31/08

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		\$ 14,114,812	\$ 431,901		\$ 489,027	\$ 57,126	\$ 5,175,781	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 14,114,812	\$ 431,901		\$ 489,027	\$ 57,126	\$ 5,175,781	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:

01/01/08

Ending:

12/31/08

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		\$ 14,114,812	\$ 431,901		\$ 489,027	\$ 57,126	\$ 5,175,781	1
2									2
3									3
4									4
5									5
6									6
7									7
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 14,114,812	\$ 431,901		\$ 489,027	\$ 57,126	\$ 5,175,781	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:

01/01/08

Ending:

12/31/08

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		\$ 14,114,812	\$ 431,901		\$ 489,027	\$ 57,126	\$ 5,175,781	1
2									2
3									3
4									4
5									5
6									6
7									7
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 14,114,812	\$ 431,901		\$ 489,027	\$ 57,126	\$ 5,175,781	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:

01/01/08

Ending:

12/31/08

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		\$ 14,114,812	\$ 431,901		\$ 489,027	\$ 57,126	\$ 5,175,781	1
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4									4
5									5
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 14,114,812	\$ 431,901		\$ 489,027	\$ 57,126	\$ 5,175,781	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:

01/01/08

Ending:

12/31/08

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		\$ 14,114,812	\$ 431,901		\$ 489,027	\$ 57,126	\$ 5,175,781	1
2									2
3									3
4									4
5									5
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 14,114,812	\$ 431,901		\$ 489,027	\$ 57,126	\$ 5,175,781	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:

01/01/08

Ending:

12/31/08

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	\$ 291,839		\$ 297,700	\$ 5,861	\$ 4,273,249	4
5											5
6											6
7											7
8											8
Improvement Type**											
9		HVAC Project		2008	1,560,000		20	78,000	78,000	78,000	9
10		Painting		2008	130,000		20	6,500	6,500	6,500	10
11		Elevator Cab		2008	43,612		20	2,181	2,181	2,181	11
12		Concrete Patio		2008	2,200		20	110	110	110	12
13		Hand Rails		2008	15,105		20	755	755	755	13
14		Nurse Station		2008	112,920		20	5,646	5,646	5,646	14
15		Side Entry Hub		2008	8,245		20	412	412	412	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:

01/01/08

Ending:

12/31/08

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)	\$	12,291,591	\$	291,839	\$	391,304	\$	99,465	\$	4,366,853	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:

01/01/08 Ending:

12/31/08

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	
	Bed* 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	\$ 35,349	\$ 1,122	35	\$ 1,010	\$ (112)	\$ 15,654	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	S.I.R. Properties - S.I.R. Management - Allocation		2007	619	120	20	31	(89)	62	9
10	S.I.R. Properties - S.I.R. Management - Allocation		2002	140	-	20	7	7	46	10
11	S.I.R. Properties - S.I.R. Management - Allocation		1999	4,479	448	20	224	(224)	2,128	11
12	S.I.R. Properties - S.I.R. Management - Allocation		1998	2,140	-	20	107	107	1,124	12
13	S.I.R. Properties - S.I.R. Management - Allocation		1997	133	-	20	7	7	83	13
14	S.I.R. Properties - S.I.R. Management - Allocation		1994	337	9	20	17	8	244	14
15	S.I.R. Properties - S.I.R. Management - Allocation		1993	573	3	20	29	26	445	15
16										16
17	S.I.R. Management - Allocation		1993	9,758	272	20	484	212	7,740	17
18	S.I.R. Management - Allocation		1994	30	-	20	-		30	18
19	S.I.R. Management - Allocation		1995	223	-	20	11	11	150	19
20	S.I.R. Management - Allocation		1997	14,993	336	20	750	414	8,853	20
21	S.I.R. Management - Allocation		1999	14,886	-	20	59	59	14,252	21
22	S.I.R. Management - Allocation		2000	1,392	-	20	70	70	594	22
23	S.I.R. Management - Allocation		2007	4,472	-	20	224	224	267	23
24	S.I.R. Management - Allocation		2008	12,325	941	20	656	(285)	656	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:

01/01/08

Ending:

12/31/08

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)	\$	101,849	\$	3,251	\$	3,686	\$	435	\$	52,328	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: 01/01/08 Ending: 12/31/08

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	\$ 655,279	\$ 7,826	\$ 48,845	\$ 41,019	10	\$ 428,594	71
72	Current Year Purchases	645,095	31,615	71,631	40,016	10	74,294	72
73	Fully Depreciated Assets	1,145,667				10	1,145,662	73
74								74
75	TOTALS	\$ 2,446,041	\$ 39,441	\$ 120,476	\$ 81,035		\$ 1,648,550	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)		\$ 17,285,844	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 471,342	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 609,502	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 138,160	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 6,824,330	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: 01/01/08

Ending: 12/31/08

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.	<u>2009</u>	\$ _____
13.	<u>2010</u>	\$ _____
14.	<u>2011</u>	\$ _____

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: \$ 13,668

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	<u>Alloc. - S.I.R. Management</u>		\$	\$ <u>1,471</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>1,471</u>	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.

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	\$		\$ 208,917	\$		\$ 208,917	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			98,112			98,112	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			360,960			360,960	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				426,639		426,639	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>			778,815		358,404	494,026		1,631,245	13
14	TOTAL			\$ 778,815		\$ 1,026,393	\$ 920,665		\$ 2,725,873	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: 01/01/08

Ending:

12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08

(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	\$ 23,902	\$ 25,447	1
2	Cash-Patient Deposits	83,019	83,019	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	3,912,715	3,912,715	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		2,040	5
6	Prepaid Insurance	90,071	90,071	6
7	Other Prepaid Expenses	5,469	5,469	7
8	Accounts Receivable (owners or related parties)	2,624,758	2,624,758	8
9	Other(specify): <u>See Attached Schedule</u>	588	349,820	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,740,522	\$ 7,093,339	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	706,467	2,578,554	15
16	Equipment, at Historical Cost	1,824,965	3,073,303	16
17	Accumulated Depreciation (book methods)	(1,881,610)	(6,763,224)	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>	11,200	1,000,194	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 661,022	\$ 11,036,327	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,401,544	\$ 18,129,666	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,516,529	\$ 1,516,529	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	83,864	83,864	28
29	Short-Term Notes Payable	5,092,691	5,092,691	29
30	Accrued Salaries Payable	483,485	483,485	30
31	Accrued Taxes Payable (excluding real estate taxes)	56,300	56,300	31
32	Accrued Real Estate Taxes(Sch.IX-B)		490,000	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>		10,000	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,232,869	\$ 7,732,869	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,624,758	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)	\$	\$ 14,507,258	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,232,869	\$ 22,240,127	46
47	TOTAL EQUITY(page 18, line 24)	\$ 168,675	\$ (4,110,461)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,401,544	\$ 18,129,666	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 111,184	1
2	Restatements (describe):		2
3	<u>Rounding</u>	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 111,185	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	69,990	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>Treasury Stock</u>	(12,500)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 57,490	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)	\$ 168,675	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care# 0040410Report Period Beginning: 01/01/08Ending: 12/31/08**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	\$ 12,102,517	1
2	Discounts and Allowances for all Levels	(1,140,683)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,961,834	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,750,460	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,750,460	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	407,435	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	26,261	19
20	Radiology and X-Ray	25,878	20
21	Other Medical Services	602,075	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,061,649	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	394	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 394	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	21,768	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 21,768	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,796,105	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,905,911	31
32	Health Care	4,761,812	32
33	General Administration	2,185,912	33
B. Capital Expense			
34	Ownership	1,951,713	34
C. Ancillary Expense			
35	Special Cost Centers	2,786,261	35
36	Provider Participation Fee	134,506	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,726,115	40
41	Income before Income Taxes (line 30 minus line 40)**	69,990	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 69,990	43

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

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

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. 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: 01/01/08

Ending:

12/31/08

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	2,643	2,871	\$ 114,441	\$ 39.86	1
2	Assistant Director of Nursing	456	456	16,260	35.66	2
3	Registered Nurses	33,206	35,174	1,057,874	30.08	3
4	Licensed Practical Nurses	26,158	26,878	653,141	24.30	4
5	CNAs & Orderlies	88,864	93,227	1,117,172	11.98	5
6	CNA Trainees					6
7	Licensed Therapist	34,568	35,321	778,815	22.05	7
8	Rehab/Therapy Aides	14,948	16,086	259,395	16.13	8
9	Activity Director	3,042	3,237	48,897	15.11	9
10	Activity Assistants	9,011	9,525	83,726	8.79	10
11	Social Service Workers	10,363	10,861	128,134	11.80	11
12	Dietician					12
13	Food Service Supervisor	1,413	1,737	28,664	16.50	13
14	Head Cook	5,008	5,522	60,924	11.03	14
15	Cook Helpers/Assistants	22,445	24,127	234,969	9.74	15
16	Dishwashers					16
17	Maintenance Workers	6,294	6,706	92,598	13.81	17
18	Housekeepers	29,245	31,487	282,452	8.97	18
19	Laundry	8,277	9,047	76,269	8.43	19
20	Administrator	2,080	2,349	108,071	46.01	20
21	Assistant Administrator	2,288	2,712	69,809	25.74	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,963	12,111	131,371	10.85	24
25	Vocational Instruction	764	764	2,909	3.81	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	9,573	10,458	209,966	20.08	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	3,874	4,592	89,074	19.40	33
34	TOTAL (lines 1 - 33)	326,483	345,248	\$ 5,644,931 *	\$ 16.35	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	\$ 23,520	01-03	35
36	Medical Director	Monthly	14,100	09-03	36
37	Medical Records Consultant	Monthly	4,320	10-03	37
38	Nurse Consultant	1,323	52,920	10-03	38
39	Pharmacist Consultant	Monthly	3,380	10-03	39
40	Physical Therapy Consultant	278	18,888	10a-03	40
41	Occupational Therapy Consultant	154	10,418	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	317	13,611	10a-03	43
44	Activity Consultant	Monthly	2,423	11-03	44
45	Social Service Consultant	82	4,233	12-03	45
46	Other(specify)				46
47	<u>Director of Food Service</u>	Monthly	26,460	01-03	47
48	<u>Specialized Rehab Consultant</u>	Monthly	26,460	10-03	48
49	TOTAL (lines 35 - 48)	2,154	\$ 200,733		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	16	\$ 751	10-03	50
51	Licensed Practical Nurses	7,851	323,246	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	7,867	\$ 323,997		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning: 01/01/08

Ending: 12/31/08

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 (01/01-08/10)	Administrator	2.04%	\$ 62,293	Workers' Compensation Insurance	\$ 144,523	IDPH License Fee	\$ 995	
Siap Menchavez (08/11-Current)	Administrator	0.00%	45,778	Unemployment Compensation Insurance	62,338	Advertising: Employee Recruitment	29,018	
Caryl Kiser (01/01-02/01)	Asst. Admin	0.00%	8,207	FICA Taxes	420,546	Health Care Worker Background Check		
Jacqueline Gully (02/01-10/28)	Asst. Admin	0.00%	54,335	Employee Health Insurance	81,265	(Indicate # of checks performed <u>385</u>)	4,620	
Gabrielle De Vera (10/22-Current)	Asst. Admin	0.00%	7,267	Employee Meals	39,111	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	12,631	
				Union Health	119,792	Licenses & Permits	1,338	
				401K Contribution	9,315	Advertising	22,778	
				Employee Benefits- Other	9,217	Yellow Page Advertising	10,084	
						See Supplemental Schedule	1,771	
						Less: Public Relations Expense	()	
						Non-allowable advertising	(22,778)	
						Yellow page advertising	(10,084)	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 177,880					
(List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)	\$ 886,107	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 50,373	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
S.I.R. Management- Owner's Council			\$ 13,236				Out-of-State Travel	\$
S.I.R. Management- Ancillary Charges			54,396					
S.I.R. Management- Dir of Administrative Services			52,920				In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 120,552				Seminar Expense	4,723
(Attach a copy of any management service agreement)							Alloc. - S.I.R. Management	551
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
Frost, Ruttenberg, & Rothblatt	Accounting		\$ 26,160					
S.I.R. Management	Accounting		36,000					
Pinnacle Consulting	Cust. Satisfaction Survey		2,642					
S.I.R. Management	Bookkeeping		102,888					
Kessler Orlean	Accounting		625					
S.I.R. Management	Dir of Regulatory Srvcs		26,460					
e-Health Data Solutions	Data Processing		2,450					
Property Valuation Services	R/E Appraisal		2,500					
Michigan Peer Review	Dispute Resolution Srvcs		2,640					
Boyer & Associates	MDS Audit Consulting		2,228					
LTC Solutions	Computer Services		1,600					
See Supplemental Schedule			83,266					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 289,459					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number Elmwood Care

Report Period Beginning: 01/01/08 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 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

