



Facility Name & ID Number Elmwood Care

# 0040410 Report Period Beginning: 01/01/09 Ending: 12/31/09

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	Private Pay	4 Other			
8	SNF	<u>58,751</u>	<u>2,356</u>	<u>8,496</u>	<u>69,603</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>58,751</u>	<u>2,356</u>	<u>8,496</u>	<u>69,603</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.83%

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 7,505

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/09 Ending: 12/31/09

**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
	<b>A. General Services</b>										
1	Dietary	339,549	88,298	61,427	489,274		489,274	(19,776)	469,498		1
2	Food Purchase		345,471		345,471	(41,282)	304,190	(573)	303,617		2
3	Housekeeping	290,606	93,354		383,960		383,960	(2,555)	381,405		3
4	Laundry	83,207	57,573		140,780		140,780		140,780		4
5	Heat and Other Utilities			261,809	261,809		261,809	(4,465)	257,344		5
6	Maintenance	93,589	60,804	352,055	506,448		506,448	(50,187)	456,261		6
7	Other (specify):*							7,388	7,388		7
8	<b>TOTAL General Services</b>	<b>806,951</b>	<b>645,500</b>	<b>675,291</b>	<b>2,127,742</b>	<b>(41,282)</b>	<b>2,086,461</b>	<b>(70,168)</b>	<b>2,016,293</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			13,800	13,800		13,800		13,800		9
10	Nursing and Medical Records	4,311,267	685,327	167,596	5,164,190		5,164,190	(105,602)	5,058,588		10
10a	Therapy	237,846		44,663	282,509		282,509	(19,752)	262,757		10a
11	Activities	119,239	6,869	2,808	128,916		128,916		128,916		11
12	Social Services	187,657		4,460	192,117		192,117		192,117		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							4,547	4,547		15
16	<b>TOTAL Health Care and Programs</b>	<b>4,856,009</b>	<b>692,196</b>	<b>233,327</b>	<b>5,781,532</b>		<b>5,781,532</b>	<b>(120,807)</b>	<b>5,660,725</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	159,203		120,552	279,755		279,755	5,707	285,462		17
18	Directors Fees										18
19	Professional Services			526,742	526,742	(250)	526,492	(268,185)	258,307		19
20	Dues, Fees, Subscriptions & Promotions			117,645	117,645		117,645	(57,593)	60,052		20
21	Clerical & General Office Expenses	147,054	64,399	710,559	922,012		922,012	(521,957)	400,055		21
22	Employee Benefits & Payroll Taxes			993,531	993,531	41,282	1,034,813		1,034,813		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,778	3,778		3,778	311	4,089		24
25	Other Admin. Staff Transportation			4,013	4,013		4,013	9,749	13,762		25
26	Insurance-Prop.Liab.Malpractice			179,735	179,735		179,735	1,296	181,031		26
27	Other (specify):*							43,053	43,053		27
28	<b>TOTAL General Administration</b>	<b>306,257</b>	<b>64,399</b>	<b>2,656,555</b>	<b>3,027,211</b>	<b>41,032</b>	<b>3,068,243</b>	<b>(787,619)</b>	<b>2,280,624</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>5,969,217</b>	<b>1,402,095</b>	<b>3,565,173</b>	<b>10,936,485</b>	<b>(250)</b>	<b>10,936,235</b>	<b>(978,594)</b>	<b>9,957,641</b>		<b>29</b>

\*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 &amp; ID Number

Elmwood Care

#0040410

Report Period Beginning:

01/01/09

Ending:

12/31/09

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	<b>D. Ownership</b>											
30	Depreciation			111,552	111,552		111,552	550,910	662,462			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			182,745	182,745		182,745	914,024	1,096,769			32
33	Real Estate Taxes			694	694	250	944	475,605	476,549			33
34	Rent-Facility & Grounds			1,824,250	1,824,250		1,824,250	(1,824,250)				34
35	Rent-Equipment & Vehicles			6,450	6,450		6,450	9,638	16,088			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			2,125,691	2,125,691	250	2,125,941	125,927	2,251,868			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	909,918	873,763	1,124,786	2,908,467		2,908,467	(46,595)	2,861,872			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			134,138	134,138		134,138		134,138			42
43	Other (specify):*	60,287			60,287		60,287	(60,287)				43
44	<b>TOTAL Special Cost Centers</b>	970,205	873,763	1,258,924	3,102,892		3,102,892	(106,882)	2,996,010			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	6,939,422	2,275,858	6,949,788	16,165,068		16,165,068	(959,549)	15,205,519			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:

01/01/09

Ending:

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**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(6,872)	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	117,048	30		9
10	Interest and Other Investment Income	(56)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(117)	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	(10,000)	20		18
19	Entertainment				19
20	Contributions	(670)	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	(587,903)	21		24
25	Fund Raising, Advertising and Promotional	(31,676)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(8,517)	20		28
29	Other-Attach Schedule	(345,683)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (874,446)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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)	(85,103)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (85,103)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (959,549)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

<b>BHF USE ONLY</b>							
48		49		50		51	52

Elmwood CareID# 0040410Report Period Beginning: 01/01/09Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Misc. Income	\$ (103)	21	1
2	Prescription Drugs- -Veterans	(1,267)	10	2
3	Bank Fees	(4,137)	21	3
4	Marketing Salaries	(60,287)	43	4
5	Capitalized R&M	(23,375)	06	5
6	COPE Dues	(7,030)	20	6
7	2010 Seminar	(95)	24	7
8	PPA - Bed Rental & Hospital Expense	(12,607)	10	8
9	PPA - Respiratory Therapy	(8,371)	39	9
10	PPA - Xcell Supply	(16,387)	06	10
11	Marketing Expense	(20,000)	21	11
12	Filing Fees - Building Co.	(309)	21	12
13	Office Expense - Building Co.	(61)	21	13
14	Professional Fees - Building Co.	(1,600)	19	14
15	Amortization - Building Company	(76,100)	36	15
16	Collections	(160)	21	16
17	Non-Allowable Legal Fees	(130,626)	19	17
18	Additional R&M	16,832	06	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	<b>Total</b>	(345,683)		49

Elmwood Care

ID# 0040410

Report Period Beginning: 01/01/09

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

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elmwood Care# 0040410

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				(19,776)								(19,776)	1
2	Food Purchase	(117)							(456)				(573)	2
3	Housekeeping						(2,555)						(2,555)	3
4	Laundry													4
5	Heat and Other Utilities	(6,872)			2,407								(4,465)	5
6	Maintenance	(22,930)		(14,575)	(12,682)								(50,187)	6
7	Other (specify):*			955	6,433								7,388	7
8	<b>TOTAL General Services</b>	<b>(29,919)</b>		<b>(13,620)</b>	<b>(23,618)</b>		<b>(2,555)</b>		<b>(456)</b>				<b>(70,168)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(13,874)		(37,461)	7,656		(45,949)		(15,974)				(105,602)	10
10a	Therapy				(19,752)								(19,752)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			2,331	2,216								4,547	15
16	<b>TOTAL Health Care and Programs</b>	<b>(13,874)</b>		<b>(35,130)</b>	<b>(9,880)</b>		<b>(45,949)</b>		<b>(15,974)</b>				<b>(120,807)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(80,779)	86,486								5,707	17
18	Directors Fees													18
19	Professional Services	(132,226)	1,600	(164,308)	15,499	11,250							(268,185)	19
20	Fees, Subscriptions & Promotions	(57,893)		300									(57,593)	20
21	Clerical & General Office Expenses	(612,673)	370	90,276	70								(521,957)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(95)		406									311	24
25	Other Admin. Staff Transportation			9,749									9,749	25
26	Insurance-Prop.Liab.Malpractice			1,153	143								1,296	26
27	Other (specify):*			25,201	17,852								43,053	27
28	<b>TOTAL General Administration</b>	<b>(802,887)</b>	<b>1,970</b>	<b>(118,002)</b>	<b>120,050</b>	<b>11,250</b>							<b>(787,619)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(846,680)</b>	<b>1,970</b>	<b>(166,752)</b>	<b>86,552</b>	<b>11,250</b>	<b>(48,504)</b>		<b>(16,430)</b>				<b>(978,594)</b>	<b>29</b>

## STATE OF ILLINOIS

Facility Name & ID Number Elmwood Care# 0040410

Report Period Beginning:

01/01/09

Ending:

Summary B

12/31/09

## 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	117,048	404,119		11,530	18,213							550,910	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(56)	932,245	(25,705)	7,540								914,024	32
33	Real Estate Taxes		468,390		7,215								475,605	33
34	Rent-Facility & Grounds		(1,824,250)										(1,824,250)	34
35	Rent-Equipment & Vehicles			9,638									9,638	35
36	Other (specify):*	(76,100)	76,100											36
37	<b>TOTAL Ownership</b>	<b>40,892</b>	<b>56,604</b>	<b>(16,067)</b>	<b>26,285</b>	<b>18,213</b>							<b>125,927</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(8,371)				(19,200)	(10,799)		(8,225)				(46,595)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(60,287)											(60,287)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(68,658)</b>				<b>(19,200)</b>	<b>(10,799)</b>		<b>(8,225)</b>				<b>(106,882)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(874,446)	58,574	(182,819)	112,837	10,263	(59,303)		(24,655)				(959,549)	45

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent - Base	\$ 1,824,250	Elmwood Grand, LLC	100.00%	\$	(1,824,250)	1
2	V	36 Amortization		Elmwood Grand, LLC	100.00%	76,100	76,100	2
3	V	30 Depreciation		Elmwood Grand, LLC	100.00%	404,119	404,119	3
4	V	21 Filing Fees		Elmwood Grand, LLC	100.00%	309	309	4
5	V	32 Interest	34,772	Elmwood Grand, LLC	100.00%	967,017	932,245	5
6	V	21 Office Expense		Elmwood Grand, LLC	100.00%	61	61	6
7	V	19 Professional Fees		Elmwood Grand, LLC	100.00%	1,600	1,600	7
8	V	33 Real Estate Taxes		Elmwood Grand, LLC	100.00%	468,390	468,390	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,859,022			\$ 1,917,596	\$ * 58,574	14

\* 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	6 REPAIRS AND MAINT.	\$ 26,460	S.I.R. MANAGEMENT, INC.	100.00%	\$ 11,885	\$ (14,575)
16	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	955	955
17	V	10 NURSING	52,920	S.I.R. MANAGEMENT, INC.	100.00%	15,459	(37,461)
18	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	2,331	2,331
19	V	19 PROFESSIONAL FEES	167,748	S.I.R. MANAGEMENT, INC.	100.00%	2,587	(165,161)
20	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	300	300
21	V	21 CLERICAL & GENERAL	52,920	S.I.R. MANAGEMENT, INC.	100.00%	35,417	(17,503)
22	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	406	406
23	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	9,749	9,749
24	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,153	1,153
25	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	4,535	4,535
26	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(25,705)	(25,705)
27	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	9,638	9,638
28	V						
29	V	17 ADMINISTRATIVE	107,316	S.I.R. MANAGEMENT, INC.	100.00%	26,537	(80,779)
30	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	853	853
31	V	21 CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	107,779	107,779
32	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	20,666	20,666
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 407,364			\$ 224,545	\$ * (182,819)

\* 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	1	DIETARY SALARIES	\$ 26,460	S.I.R. MANAGEMENT, INC.	100.00%	\$ 6,684	\$ (19,776)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,033	1,033	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	7,656	7,656	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	1,164	1,164	18
19	V	17	ADMIN./LEGAL SALARIES	13,236	S.I.R. MANAGEMENT, INC.	100.00%	99,722	86,486	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	15,440	15,440	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	17,852	17,852	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	26,460	S.I.R. MANAGEMENT, INC.	100.00%	6,708	(19,752)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,052	1,052	25
26	V								26
27	V	6	MAINTENANCE SALARIES	43,010	S.I.R. MANAGEMENT, INC.	100.00%	29,639	(13,371)	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	5,400	5,400	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	2,407	2,407	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	689	689	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	59	59	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	70	70	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	143	143	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	11,530	11,530	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	7,540	7,540	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	7,215	7,215	37
38	V								38
39	Total		\$ 109,166				\$ 222,003	\$ * 112,837	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	39 LEASED EQUIPMENT	19,200	S.I.R. MANAGEMENT, INC.	100.00%		\$ (19,200)
16	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	18,213	18,213
17	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%		
18	V						
19	V						
20	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	11,250	11,250
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 19,200			\$ 29,463	\$ * 10,263

\* 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	1 Dietary	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	3 Housekeeping	27,825	Xcel Supply, LLC	100.00%	25,270	(2,555)	16
17	V	4 Laundry		Xcel Supply, LLC	100.00%			17
18	V	6 Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10 Nursing	500,362	Xcel Supply, LLC	100.00%	454,413	(45,949)	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	117,594	Xcel Supply, LLC	100.00%	106,795	(10,799)	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		\$ 645,781			\$ 586,478	\$ * (59,303)	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%	\$ 137,654	\$ 137,654	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	137,654	CCS Employee Benefits Group	100.00%		(137,654)	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		\$ 137,654			\$ 137,654	\$ *	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	39 Enterals	\$ 19,168	Care Centers Health Systems, Inc.		\$ 10,943	\$ (8,225)
16	V	10 Nursing / Infusion Supplies	37,226	Care Centers Health Systems, Inc.		21,252	(15,974)
17	V	2 Food	1,064	Care Centers Health Systems, Inc.		608	(456)
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 57,458			\$ 32,803	\$ * (24,655)

\* 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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	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	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name &amp; ID Number

Elmwood Care

# 0040410

Report Period Beginning:

01/01/09

Ending:

12/31/09

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Relative	Administrative	0	See Attached	0.60	1.29%	Alloc. Salary	\$ 8,634	17-7	1
2	Bryan Barrish	Shareholder	Administrative	14.25%	See Attached	2.59	6.48%	Alloc. Salary	16,836	17-7	2
3	Michael Giannini	Shareholder	Administrative	11.57%	See Attached	3.02	7.55%	Alloc. Salary	14,413	17-7	3
4	Sarah Barrish	Relative	Administrative	0	See Attached	3.45	8.63%	Alloc. Salary	8,803	17-7	4
5	Kirsten Barrish	Relative	Clerical	0	See Attached	1.47	8.65%	Alloc. Salary	1,167	21-7	5
6	Nenita Guzman	Relative	Dietary	0	See Attached	4.32	8.64%	Alloc. Salary	6,684	1-7	6
7	Louise Bergthold	Shareholder	Administrative	4.94%	See Attached	4.75	8.64%	Alloc. Salary	16,836	17-7	7
8	Tom Winter	Shareholder	Administrative	1.44%	See Attached	4.96	8.27%	Alloc. Salary	16,126	17-7	8
9	Jeff Oravec	Shareholder	Administrative	0.41%	See Attached	3.31	8.28%	Alloc. Salary	10,411	17-7	9
10	Joey Abramchick	Shareholder	Administrative	2.06%	See Attached	3.89	8.64%	Alloc. Salary	15,440	17-7	10
11	Elka Abramchick	Relative	Clerical	0	See Attached	2.89	8.26%	Alloc. Salary	2,939	21-7	11
12	Adam Vales	Shareholder	Clerical	2.88%	See Attached	0.80	2.00%	Alloc. Salary	1,444	22-7	12
13								TOTAL	\$ 119,733		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:

01/01/09

Ending: 12/31/09

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

# 0040410

Report Period Beginning:

01/01/09

Ending: 12/31/09

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	6	REPAIRS AND MAINT.	PATIENT DAYS	806,183	12	\$ 137,654	\$ 73,265	69,603	\$ 11,885	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	806,183	12	11,057		69,603	955	2
3	10	NURSING	PATIENT DAYS	806,183	12	179,054	179,054	69,603	15,459	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	806,183	12	27,001		69,603	2,331	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	806,183	12	29,965	15,891	69,603	2,587	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	806,183	12	3,480		69,603	300	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	806,183	12	410,223	335,902	69,603	35,417	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	806,183	12	4,701		69,603	406	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	806,183	12	112,924		69,603	9,749	9
10	26	INSURANCE	PATIENT DAYS	806,183	12	13,360		69,603	1,153	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	806,183	12	52,522		69,603	4,535	11
12	32	INTEREST	PATIENT DAYS	806,183	12	(297,734)		69,603	(25,705)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	806,183	12	111,631		69,603	9,638	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	841,652	13	320,892	320,892	69,603	26,537	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	841,652	13	10,309		69,603	853	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	841,652	13	1,303,285	68,837	69,603	107,779	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	841,652	13	249,900		69,603	20,666	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,680,224	\$ 993,841		\$ 224,545	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

# 0040410

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY SALARIES	PATIENT DAYS	806,183	12	\$ 77,418	\$ 77,418	69,603	\$ 6,684	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	806,183	12	11,962		69,603	1,033	2
3	10	NURSING SALARIES	PATIENT DAYS	806,183	12	88,682	88,682	69,603	7,656	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	806,183	12	13,479		69,603	1,164	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	806,183	12	1,155,033	1,155,033	69,603	99,722	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	806,183	12	178,836		69,603	15,440	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	806,183	12	206,767		69,603	17,852	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	273,348	13	69,299	69,299	26,460	6,708	10
11	15	EMPLOYEE BENEFITS	SPECIAL REHAB INC.	273,348	13	10,868		26,460	1,052	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	257,623	9	177,531	177,531	43,010	29,639	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	257,623	9	32,348		43,010	5,400	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	13	28,260		1,097	2,407	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	13	8,091		1,097	689	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	13	689		1,097	59	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	13	822		1,097	70	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	13	1,678		1,097	143	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	13	135,367		1,097	11,530	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	13	88,526		1,097	7,540	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	13	84,702		1,097	7,215	23
24										24
25	TOTALS					\$ 2,370,358	\$ 1,567,963		\$ 222,003	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

# 0040410

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	30	DEPRECIATION	LEASING INCOME	19,200	1	18,213	19,200	18,213	3
4	32	INTEREST	LEASING INCOME	19,200	1		19,200		4
5									5
6									6
7	19	PROFESSIONAL FEES	DIRECT ALLOCATION		1	11,250	1	11,250	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					\$ 29,463	\$	\$ 29,463	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

# 0040410

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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					25,270	2
3	4	Laundry	Direct Allocation						3
4	6	Repairs & Maintenance	Direct Allocation						4
5	10	Nursing	Direct Allocation					454,413	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					106,795	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				\$	\$		\$ 586,478	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

# 0040410

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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		\$	\$		\$ 137,654	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				\$	\$		\$ 137,654	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

# 0040410

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization Care Centers Health Systems, Inc.  
 Street Address 200 Howard  
 City / State / Zip Code Des Plaines, Illinois 60018  
 Phone Number ( 224) 612-5662  
 Fax Number ( 224) 612-5862

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.

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	39	Enterals	Direct Allocation		\$	\$		10,943	1
2	10	Nursing / Infusion Supplies	Direct Allocation					21,252	2
3	2	Food	Direct Allocation					608	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				\$	\$		32,803	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

# 0040410

Report Period Beginning:

01/01/09

Ending: 12/31/09

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

# 0040410 Report Period Beginning: 01/01/09 Ending: 12/31/09

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

# 0040410

Report Period Beginning:

01/01/09

Ending: 12/31/09

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Elmwood Care

# 0040410

Report Period Beginning:

01/01/09

Ending:

12/31/09

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6	7	8	9	10											
											Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
												YES	NO				Original	Balance			
	<b>A. Directly Facility Related</b>																				
	<b>Long-Term</b>																				
1	Midwest Bank		X	Mortgage			\$	\$ 14,622,363			\$ 967,017	1									
2												2									
3												3									
4												4									
5	See Supplemental Schedule											5									
	<b>Working Capital</b>																				
6	Lake Forest Bank		X	Line of Credit				2,936,962			182,745	6									
7	Partners	X		Loans Payable				1,000,000				7									
8	See Supplemental Schedule							1,000,000				8									
9	TOTAL Facility Related						\$	\$ 19,559,325			\$ 1,149,762	9									
	<b>B. Non-Facility Related*</b>																				
10	Interest Income		X								(56)	10									
11	Interest Income - Bldg. Co	X									(34,772)	11									
12	SIR Management	X									(18,165)	12									
13	See Supplemental Schedule											13									
14	TOTAL Non-Facility Related						\$	\$			\$ (52,993)	14									
15	TOTALS (line 9+line14)						\$	\$ 19,559,325			\$ 1,096,769	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:

01/01/09

Ending:

12/31/09

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
	<b>A. Directly Facility Related</b>																		
	<b>Long-Term</b>																		
1							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	<b>TOTAL Long-Term</b>																		
	<b>Working Capital</b>																		
8	SIR Management			Note Payable			\$	\$ 1,000,000			\$	8							
9												9							
10												10							
11												11							
12												12							
13												13							
14	<b>TOTAL Working Capital</b>																		
	<b>B. Non-Facility Related*</b>																		
15							\$	\$			\$	15							
16												16							
17												17							
18												18							
19												19							
20	<b>TOTAL Non-Facility Related</b>																		

\* 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:

01/01/09

Ending:

12/31/09

**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:**

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

# 0040410

Report Period Beginning:

01/01/09

Ending:

12/31/09

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Various		1993	129,203		20	6,460	6,460	105,206	9
10	Various		1994	49,738		20	2,487	2,487	38,656	10
11	Various		1995	167,102		20	8,357	8,357	121,444	11
12	Various		1996	136,090		20	6,804	6,804	90,924	12
13	Various		1997	16,180		20	809	809	10,149	13
14	Various		1998	158,155		20	6,540	6,540	101,845	14
15	Various		1999	121,088		20	6,056	6,056	63,765	15
16	Various		2000	67,583		20	3,382	3,382	31,972	16
17	Various		2001	107,654		20	5,382	5,382	46,278	17
18	Various		2002	113,214		20	11,043	11,043	82,781	18
19	Various		2003	145,109		20	7,812	7,812	50,336	19
20	Various		2004	124,757		20	5,954	5,954	35,568	20
21	Various		2005	84,119		20	4,707	4,707	22,729	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

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	Related Building Company (Pages 12F & 12G)	13,037,673	404,119		428,608	24,489	4,795,461	67
68	Related Party Allocations (Pages 12H & 12I)	138,898	5,604		4,407	(1,197)	58,563	68
69	Financial Statement Depreciation		111,552			(111,552)		69
70	TOTAL (lines 4 thru 69)	\$ 14,596,563	\$ 521,275		\$ 508,808	\$ (12,467)	\$ 5,655,677	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Elmwood Care

# 0040410

Report Period Beginning:

01/01/09

Ending:

12/31/09

## 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	<b>Totals from Page 12A, Carried Forward</b>		\$ 14,596,563	\$ 521,275		\$ 508,808	\$ (12,467)	\$ 5,655,677	1
2	Water Heater	2006	3,534		20	353	353	1,414	2
3	Flooring	2006	7,000		20	350	350	1,400	3
4	Electric Upgrade	2006	7,159		20	358	358	1,253	4
5	Hvac Piping	2006	7,127		20	713	713	2,494	5
6	Fire System	2006	6,572		20	329	329	1,260	6
7	Water Pump	2006	2,534		20	127	127	475	7
8	Hvac Compressor	2006	4,404		20	220	220	752	8
9	Fire Door Work	2006	2,800		20	140	140	478	9
10	Elevator Repairs	2006	17,698		20	885	885	3,318	10
11	Basement Repiping	2006	68,859		20	3,443	3,443	10,616	11
12	Drapes	2007	5,309		20	531	531	1,593	12
13	Windows	2007	2,847		20	285	285	854	13
14	Pipe Insulation	2007	16,426		20	821	821	2,259	14
15	Pipe Insulation	2007	5,636		20	282	282	775	15
16	Exhaust Fans	2007	2,596		20	260	260	649	16
17	Boiler Work	2007	2,763		20	138	138	414	17
18	Concrete And Sewer	2007	2,200		20	110	110	312	18
19	Mixing Valves	2007	3,800		20	190	190	538	19
20	Cable/Phone Wire	2007	1,717		20	86	86	243	20
21	Cable/Phone Wire	2007	3,864		20	193	193	547	21
22	Fire Alarm System	2007	9,235		20	462	462	1,270	22
23	Low Pressure Alarms	2007	2,823		20	141	141	376	23
24	Hvac Work	2007	10,564		20	528	528	1,409	24
25	Ejector Pump	2007	1,563		20	156	156	365	25
26	Chemical Pump	2007	2,051		20	205	205	479	26
27	Electrical Work	2007	4,868		20	243	243	548	27
28	Flooring	2007	12,751		20	638	638	1,434	28
29	Low Air Loss Alarm	2007	7,058		20	706	706	1,588	29
30	Hot Water Valve	2007	2,188		20	219	219	492	30
31	Low Air Loss Alarm	2007	5,646		20	565	565	1,223	31
32	Boiler	2007	1,863		20	186	186	404	32
33	Electrical Work	2007	3,877		20	194	194	404	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 14,835,895	\$ 521,275		\$ 522,865	\$ 1,590	\$ 5,697,313	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Elmwood Care

# 0040410

Report Period Beginning:

01/01/09

Ending:

12/31/09

## 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	<b>Totals from Page 12B, Carried Forward</b>		\$ 14,835,895	\$ 521,275		\$ 522,865	\$ 1,590	\$ 5,697,313	1
2	Sewer Pump	2007	5,300		20	265	265	596	2
3	Fire Doors	2007	2,860		20	143	143	298	3
4	Fire Doors	2007	4,183		20	209	209	436	4
5	2008 Audit Adjustment 2007	2007	(12,836)		20	(1,284)	(1,284)	(2,674)	5
6	Cubicle Curtains	2007	3,261		20	163	163	462	6
7	Alarm System	2007	2,767		20	138	138	346	7
8	Boiler Work	2008	10,825		20			1,083	8
9	Fire Door	2008	2,460		20	123	123	185	9
10	Curtains	2008	10,230		20	512	512	725	10
11	Flooring - Vinyl Rock / Gridstone Tiles	2008	3,320		20	166	166	208	11
12	Surveillance System	2008	3,424		20	171	171	214	12
13	Flooring - Vinyl	2008	4,400		20	220	220	275	13
14	Ejector Pump, Boiler, 7 Exhaust	2008	2,909		20	145	145	242	14
15	Sprinkler System	2008	6,566		20	328	328	410	15
16	Elevator Tracks	2008	7,056		20	353	353	529	16
17	Ejector Pumps / Piping	2008	5,323		20	266	266	510	17
18	Hvac Work	2009	10,548		20	527	527	527	18
19	Exhaust Fans	2009	11,567		20	578	578	578	19
20	Whirlpool Tub	2009	8,899		20	371	371	371	20
21	Boiler Room Dampers	2009	4,983		20	187	187	187	21
22	Parking Lot	2009	37,500		20	938	938	938	22
23	Security System	2009	2,948		20	98	98	98	23
24	Outdoor Storage Building	2009	5,118		20	11	11	11	24
25	Outdoor Storage Building	2009	3,058		20	6	6	6	25
26	Window Treatments	2009	7,260		20	30	30	30	26
27	Walk-In Cooler Work	2009	9,538		20	477	477	477	27
28	Water Heater Repair	2009	4,125		20	206	206	206	28
29	Chiller Start Up	2009	2,995		20	150	150	150	29
30	Rod Floor Drains	2009	3,056		20	153	153	153	30
31	Sprinkler Repair	2009	3,661		20	183	183	183	31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 15,013,199	\$ 521,275		\$ 528,698	\$ 7,423	\$ 5,705,073	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 15,013,199	\$ 521,275		\$ 528,698	\$ 7,423	\$ 5,705,073	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 15,013,199	\$ 521,275		\$ 528,698	\$ 7,423	\$ 5,705,073	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$ 15,013,199	\$ 521,275		\$ 528,698	\$ 7,423	\$ 5,705,073
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 15,013,199	\$ 521,275		\$ 528,698	\$ 7,423	\$ 5,705,073

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Elmwood Care

# 0040410

Report Period Beginning:

01/01/09

Ending:

12/31/09

## 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	<b>Building Company Information</b>								1
2	<b>Buildings:</b>								2
3		1975	10,419,509	404,119	35	297,700	(106,419)	4,570,949	3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	HVAC Project	2008	1,560,000		20	78,000	78,000	156,000	9
10	Painting	2008	130,000		20	6,500	6,500	13,000	10
11	Elevator Cab	2008	43,612		20	2,181	2,181	4,362	11
12	Concrete Patio	2008	2,200		20	110	110	220	12
13	Hand Rails	2008	15,105		20	755	755	1,510	13
14	Nurse Station	2008	112,920		20	5,646	5,646	11,292	14
15	Side Entry Hub	2008	8,245		20	412	412	824	15
16	Nurses Stations	2009	37,640		20	1,882	1,882	1,882	16
17	Window Treatment	2009	6,775		20	339	339	339	17
18	1st Floor Tile	2009	126,810		20	6,341	6,341	6,341	18
19	Resident Bathroom/Dayroom - Ceiling, Fixtures, Tiles, Paint	2009	202,085		20	10,104	10,104	10,104	19
20	Wiring	2009	22,534		20	1,127	1,127	1,127	20
21	Windows	2009	3,200		20	160	160	160	21
22	Lower Level Mall-Ceiling, Plumbing, Doors, Paint	2009	201,263		20	10,063	10,063	10,063	22
23	Painting	2009	15,000		20	750	750	750	23
24	Lower Level Mall-Drawings for Construction Permit	2009	9,000		20	450	450	450	24
25	2nd Floor Work	2009	23,400		20	1,170	1,170	1,170	25
26	2nd Floor Ceiling	2009	16,070		20	804	804	804	26
27	Sprinkler System Renovation	2009	11,017		20	551	551	551	27
28	Chair rail in dining Room	2009	11,312		20	566	566	566	28
29	Handrails - Floors 2,3,4	2009	44,652		20	2,233	2,233	2,233	29
30	Wallbase - Floors 2,3,4	2009	15,324		20	766	766	766	30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (12F & 12G lines 1 thru 33)	\$ 13,037,673	\$ 404,119		\$ 428,608	\$ 24,489	\$ 4,795,461

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	<b>Related Party Information</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3	<b>SIR Properties - SIR Management</b>	1993	38,557	1,224	35	1,102	(122)	18,176	3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	S.I.R. Management - Allocation	1993	9,775	272	20	485	213	8,239	9
10	S.I.R. Management - Allocation	1994	30		20			30	10
11	S.I.R. Management - Allocation	1995	223		20	11	11	161	11
12	S.I.R. Management - Allocation	1997	15,021	336	20	751	415	9,620	12
13	S.I.R. Management - Allocation	1999	1,181		20	59	59	605	13
14	S.I.R. Management - Allocation	1999	13,707		20			13,707	14
15	S.I.R. Management - Allocation	2000	1,394		20	70	70	665	15
16	S.I.R. Management - Allocation	2007	4,480	799	20	224	(575)	492	16
17	S.I.R. Management - Allocation	2008	12,347	1,235	20	778	(457)	1,436	17
18	S.I.R. Management - Allocation	2009	30,682	61	20	375	314	375	18
19									19
20	S.I.R. Properties - S.I.R. Management - Allocation	2009	2,315	1,323	20	93	(1,230)	93	20
21	S.I.R. Properties - S.I.R. Management - Allocation	2007	675	98	20	34	(64)	101	21
22	S.I.R. Properties - S.I.R. Management - Allocation	2002	153		20	8	8	58	22
23	S.I.R. Properties - S.I.R. Management - Allocation	1999	4,886	244	20	244		2,565	23
24	S.I.R. Properties - S.I.R. Management - Allocation	1998	2,335		20	117	117	1,342	24
25	S.I.R. Properties - S.I.R. Management - Allocation	1997	145		20	7	7	98	25
26	S.I.R. Properties - S.I.R. Management - Allocation	1994	367	9	20	18	9	284	26
27		1993	625	3	20	31	28	516	27
28									28
29									29
30									30
31									31
32									32
33									33
34									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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12H & 12I lines 1 thru 33)	\$ 138,898	\$ 5,604		\$ 4,407	\$ (1,197)	\$ 58,563	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:

01/01/09

Ending:

12/31/09

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	\$ 1,146,475	\$ 5,744	\$ 96,376	\$ 90,632	10	\$ 507,317	71
72	Current Year Purchases	315,255	18,394	37,081	18,687	10	37,081	72
73	Fully Depreciated Assets	1,199,658		306	306	10	1,199,658	73
74								74
75	TOTALS	\$ 2,661,388	\$ 24,138	\$ 133,763	\$ 109,625		\$ 1,744,056	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)	\$ 18,399,578	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 545,413	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 662,461	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 117,048	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,449,129	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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.  YES  NO

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

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

**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: \$ 16,088 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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. \_\_\_\_\_/2009 \$ \_\_\_\_\_

13. \_\_\_\_\_/2010 \$ \_\_\_\_\_

14. \_\_\_\_\_/2011 \$ \_\_\_\_\_

\* 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	2		
		Drop-outs	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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

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

- (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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	39 - 03	hrs					\$ 270,804							\$ 270,804	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					157,351							157,351	2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39 - 03	hrs					357,813							357,813	4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy	39 - 02	# of prescrpts							378,627					378,627	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															12
13	Other (specify): <b>See Supplemental</b>				909,918			338,818		495,136					1,743,872	13
14	<b>TOTAL</b>				\$ 909,918			\$ 1,124,786		\$ 873,763					\$ 2,908,467	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: 01/01/09Ending: 12/31/09

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 3,714	\$ 1,026,322	1
2	Cash-Patient Deposits	112,353	112,353	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	3,542,646	3,542,646	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	93,125	93,125	6
7	Other Prepaid Expenses	3,691	3,691	7
8	Accounts Receivable (owners or related parties)	127,892	127,892	8
9	Other(specify): <u>See Attached Schedule</u>		188,850	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,883,421	\$ 5,094,879	10
<b>B. Long-Term Assets</b>				
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	789,845	3,408,009	15
16	Equipment, at Historical Cost	2,117,199	3,473,309	16
17	Accumulated Depreciation (book methods)	(1,993,162)	(7,278,895)	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>		132,819	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 913,882	\$ 10,882,742	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,797,303	\$ 15,977,621	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 948,917	\$ 948,917	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	112,631	112,631	28
29	Short-Term Notes Payable	3,936,962	3,936,962	29
30	Accrued Salaries Payable	346,062	346,062	30
31	Accrued Taxes Payable (excluding real estate taxes)	106,974	106,974	31
32	Accrued Real Estate Taxes(Sch.IX-B)		489,000	32
33	Accrued Interest Payable		52,660	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>			36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 5,451,546	\$ 5,993,206	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable		1,000,000	39
40	Mortgage Payable		14,622,363	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 15,622,363	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 5,451,546	\$ 21,615,569	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (654,243)	\$ (5,637,948)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,797,303	\$ 15,977,621	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>168,674</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>168,674</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(822,917)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(822,917)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(654,243)</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care# 0040410Report Period Beginning: 01/01/09Ending: 12/31/09

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 12,896,623	1
2	Discounts and Allowances for all Levels	(966,265)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 11,930,358	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,987,560	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,987,560	8
<b>C. Other Operating Revenue</b>			
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	343,086	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	35,613	19
20	Radiology and X-Ray	21,560	20
21	Other Medical Services	587,125	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 987,384	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	56	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 56	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	436,793	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 436,793	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 15,342,151	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,127,742	31
32	Health Care	5,781,532	32
33	General Administration	3,027,211	33
<b>B. Capital Expense</b>			
34	Ownership	2,125,691	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	2,968,754	35
36	Provider Participation Fee	134,138	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 16,165,068	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(822,917)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (822,917)	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:

01/01/09

Ending:

12/31/09

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	2,043	2,086	\$ 97,926	\$ 46.94	1
2	Assistant Director of Nursing	938	973	44,215	45.44	2
3	Registered Nurses	37,716	39,710	1,254,903	31.60	3
4	Licensed Practical Nurses	44,336	45,809	1,209,583	26.40	4
5	CNAs & Orderlies	122,416	127,770	1,473,842	11.54	5
6	CNA Trainees					6
7	Licensed Therapist	38,947	40,320	909,918	22.57	7
8	Rehab/Therapy Aides	7,552	8,082	237,846	29.43	8
9	Activity Director	2,195	2,243	37,509	16.72	9
10	Activity Assistants	8,373	8,920	81,730	9.16	10
11	Social Service Workers	12,693	13,767	187,657	13.63	11
12	Dietician					12
13	Food Service Supervisor	2,486	2,621	46,141	17.60	13
14	Head Cook	5,287	5,860	62,476	10.66	14
15	Cook Helpers/Assistants	22,099	23,594	230,932	9.79	15
16	Dishwashers					16
17	Maintenance Workers	6,260	6,825	93,589	13.71	17
18	Housekeepers	29,166	31,781	290,606	9.14	18
19	Laundry	8,787	9,312	83,207	8.94	19
20	Administrator	1,925	2,086	109,299	52.40	20
21	Assistant Administrator	1,682	1,717	49,904	29.06	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,246	12,734	144,314	11.33	24
25	Vocational Instruction	697	697	2,740	3.93	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	10,088	10,721	202,708	18.91	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,899	4,302	88,377	20.54	33
34	TOTAL (lines 1 - 33)	381,831	401,930	\$ 6,939,422 *	\$ 17.27	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	\$ 34,967	01-03	35
36	Medical Director	Monthly	13,800	09-03	36
37	Medical Records Consultant	Monthly	4,328	10-03	37
38	Nurse Consultant	1,323	52,920	10-03	38
39	Pharmacist Consultant	Monthly	3,465	10-03	39
40	Physical Therapy Consultant	248	16,846	10a-03	40
41	Occupational Therapy Consultant	144	9,735	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	421	18,082	10a-03	43
44	Activity Consultant	Monthly	2,808	11-03	44
45	Social Service Consultant	86	4,460	12-03	45
46	Other(specify)				46
47	Director of Food Service	Monthly	26,460	01-03	47
48	Specialized Rehab Consultant	Monthly	26,460	10-03	48
49	TOTAL (lines 35 - 48)	2,222	\$ 214,331		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses			50	
51	Licensed Practical Nurses	2,065	80,423	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,065	\$ 80,423		53

SEE ACCOUNTANTS' COMPILATION REPORT



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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
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12													
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14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Elmwood Care

# 0040410

Report Period Beginning:

01/01/09

Ending:

12/31/09

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. ICLTC-\$7,316; II HC Assoc.-\$2,940
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,307 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- 
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 134,138  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 41,282 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.