

Facility Name & ID Number Elmwood Care

0040410 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	245	Skilled (SNF)	245	89,425	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	245	TOTALS	245	89,425	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	61,457	2,146	7,718	71,321	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	61,457	2,146	7,718	71,321	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.76%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 04/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES Date 04/01/93 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 245 and days of care provided 6,994

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: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	365,706	65,278	61,459	492,443		492,443	(19,922)	472,521		1
2	Food Purchase		375,044		375,044	(43,844)	331,200	(112)	331,088		2
3	Housekeeping	283,460	89,799		373,259		373,259	(5,557)	367,702		3
4	Laundry	98,074	52,632		150,706		150,706	(63)	150,643		4
5	Heat and Other Utilities			248,464	248,464		248,464	(2,800)	245,664		5
6	Maintenance	99,616	57,166	393,445	550,227		550,227	(24,422)	525,805		6
7	Other (specify):*							7,007	7,007		7
8	TOTAL General Services	846,856	639,919	703,368	2,190,143	(43,844)	2,146,299	(45,869)	2,100,430		8
	B. Health Care and Programs										
9	Medical Director			13,800	13,800		13,800		13,800		9
10	Nursing and Medical Records	4,213,414	771,189	69,978	5,054,581		5,054,581	(98,187)	4,956,394		10
10a	Therapy	219,981		51,784	271,765		271,765	(17,935)	253,830		10a
11	Activities	120,370	10,844	2,448	133,662		133,662		133,662		11
12	Social Services	235,459		4,792	240,251		240,251		240,251		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							5,194	5,194		15
16	TOTAL Health Care and Programs	4,789,224	782,033	142,802	5,714,059		5,714,059	(110,928)	5,603,131		16
	C. General Administration										
17	Administrative	245,601		120,552	366,153		366,153	(6,190)	359,963		17
18	Directors Fees										18
19	Professional Services			255,860	255,860	(626)	255,234	(186,028)	69,206		19
20	Dues, Fees, Subscriptions & Promotions			104,702	104,702		104,702	(53,163)	51,539		20
21	Clerical & General Office Expenses	142,978	51,659	847,796	1,042,433		1,042,433	(646,189)	396,244		21
22	Employee Benefits & Payroll Taxes			1,029,890	1,029,890	43,844	1,073,734		1,073,734		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,176	6,176		6,176	(18)	6,158		24
25	Other Admin. Staff Transportation			3,277	3,277		3,277	8,689	11,966		25
26	Insurance-Prop.Liab.Malpractice			199,462	199,462		199,462	1,578	201,040		26
27	Other (specify):*							44,816	44,816		27
28	TOTAL General Administration	388,579	51,659	2,567,715	3,007,953	43,218	3,051,171	(836,505)	2,214,666		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,024,659	1,473,611	3,413,885	10,912,155	(626)	10,911,529	(993,303)	9,918,226		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Elmwood Care

#0040410

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	
	D. Ownership											
30	Depreciation			107,557	107,557		107,557	583,335	690,892			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			172,416	172,416		172,416	939,589	1,112,005			32
33	Real Estate Taxes					626	626	578,554	579,180			33
34	Rent-Facility & Grounds			1,884,000	1,884,000		1,884,000	(1,884,000)				34
35	Rent-Equipment & Vehicles			8,071	8,071		8,071	10,011	18,082			35
36	Other (specify):*							0	0			36
37	TOTAL Ownership			2,172,044	2,172,044	626	2,172,670	227,489	2,400,159			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	906,697	770,574	1,100,156	2,777,427		2,777,427	(29,367)	2,748,060			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):*	23,965		333	24,298		24,298	(24,298)				43
44	TOTAL Special Cost Centers	930,662	770,574	1,234,627	2,935,863		2,935,863	(53,665)	2,882,198			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,955,321	2,244,185	6,820,556	16,020,062		16,020,062	(819,478)	15,200,584			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:

01/01/10

Ending:

12/31/10

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(5,454)	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	143,072	30		9
10	Interest and Other Investment Income	(1,468)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(112)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(3,885)	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	(750,827)	21		24
25	Fund Raising, Advertising and Promotional	(41,349)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(617,034)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,277,057)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	457,579		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 457,579		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (819,478)		37

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

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

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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Elmwood CareID# 0040410Report Period Beginning: 01/01/10Ending: 12/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Therapy Expenses - VA	\$ (1,658)	10	1
2	Misc. Income	(1,225)	21	2
3	Bank Fees	(3,861)	21	3
4	COPE Dues	(8,180)	20	4
5	Marketing Salaries	(23,965)	43	5
6	Collections	(845)	21	6
7	Non-allowable Seminar	(95)	24	7
8	Prior year Seminar	95	24	8
9	Non-allowable Legal	(1,830)	19	9
10	Capitized R&M	(15,168)	06	10
11	Additional R&M	7,023	06	11
12	Filing Fees- Building Co.	(309)	21	12
13	Amortization- Building Co.	(66,410)	36	13
14	Office Expense- Building Co.	(406)	21	14
15	Non-allowable expense- Brad Giannini	(333)	43	15
16	Settlement Payments- Building Company	(499,867)	36	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(617,034)		49

Elmwood Care

ID# 0040410

Report Period Beginning: 01/01/10

Ending: 12/31/10

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:

01/01/10

Ending:

12/31/10

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				(18,580)		(1,342)						(19,922)	1
2	Food Purchase	(112)											(112)	2
3	Housekeeping						(5,557)						(5,557)	3
4	Laundry						(63)						(63)	4
5	Heat and Other Utilities	(5,454)			2,654								(2,800)	5
6	Maintenance	(8,145)		(12,348)	(3,929)								(24,422)	6
7	Other (specify):*			1,053	5,954								7,007	7
8	TOTAL General Services	(13,711)		(11,295)	(13,901)		(6,962)						(45,869)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,658)		(36,502)	8,138		(36,649)		(31,516)				(98,187)	10
10a	Therapy				(17,935)								(17,935)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			2,566	2,628								5,194	15
16	TOTAL Health Care and Programs	(1,658)		(33,936)	(7,169)		(36,649)		(31,516)				(110,928)	16
	C. General Administration													
17	Administrative			(78,114)	71,924								(6,190)	17
18	Directors Fees													18
19	Professional Services	(1,830)		(163,130)	16,404	(37,472)							(186,028)	19
20	Fees, Subscriptions & Promotions	(53,414)		251									(53,163)	20
21	Clerical & General Office Expenses	(757,473)	715	110,492	77								(646,189)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			(18)									(18)	24
25	Other Admin. Staff Transportation			8,689									8,689	25
26	Insurance-Prop.Liab.Malpractice			1,445	133								1,578	26
27	Other (specify):*			29,362	15,454								44,816	27
28	TOTAL General Administration	(812,717)	715	(91,023)	103,992	(37,472)							(836,505)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(828,087)	715	(136,254)	82,922	(37,472)	(43,611)		(31,516)				(993,303)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Elmwood Care# 0040410

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	143,072	419,817		9,518	10,928							583,335	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,468)	968,090	(37,236)	7,930	2,273							939,589	32
33	Real Estate Taxes		574,343		4,211								578,554	33
34	Rent-Facility & Grounds		(1,884,000)										(1,884,000)	34
35	Rent-Equipment & Vehicles			10,011									10,011	35
36	Other (specify):*	(566,277)	566,277										0	36
37	TOTAL Ownership	(424,673)	644,527	(27,225)	21,659	13,201							227,489	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(24,000)	(5,367)						(29,367)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(24,298)											(24,298)	43
44	TOTAL Special Cost Centers	(24,298)				(24,000)	(5,367)						(53,665)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,277,057)	645,242	(163,479)	104,581	(48,271)	(48,978)		(31,516)				(819,478)	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: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	34 Rent-Base	\$ 1,884,000	Elmwood Grand, LLC	100.00%	\$	(1,884,000)	1	
2	V	36 Amortization		Elmwood Grand, LLC	100.00%	66,410	66,410	2	
3	V	30 Depreciation		Elmwood Grand, LLC	100.00%	419,817	419,817	3	
4	V	21 Filing Fees		Elmwood Grand, LLC	100.00%	309	309	4	
5	V	32 Interest	6,529	Elmwood Grand, LLC	100.00%	974,619	968,090	5	
6	V	21 Office Expense		Elmwood Grand, LLC	100.00%	406	406	6	
7	V	33 Real Estate Taxes		Elmwood Grand, LLC	100.00%	574,343	574,343	7	
8	V	36 Settlement Payments		Elmwood Grand, LLC	100.00%	499,867	499,867	8	
9	V							9	
10	V							10	
11	V							11	
12	V							12	
13	V							13	
14	Total		\$ 1,890,529			\$ 2,535,771	\$ *	645,242	14

* 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	6 REPAIRS AND MAINT.	\$ 26,460	S.I.R. MANAGEMENT, INC.	100.00%	\$ 14,112	\$ (12,348)
16	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	1,053	1,053
17	V	10 NURSING	52,920	S.I.R. MANAGEMENT, INC.	100.00%	16,418	(36,502)
18	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	2,566	2,566
19	V	19 PROFESSIONAL FEES	165,348	S.I.R. MANAGEMENT, INC.	100.00%	2,218	(163,130)
20	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	251	251
21	V	21 CLERICAL & GENERAL	52,920	S.I.R. MANAGEMENT, INC.	100.00%	62,385	9,465
22	V	24 EDUCATION & SEMINAR	1,080	S.I.R. MANAGEMENT, INC.	100.00%	1,062	(18)
23	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	8,689	8,689
24	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,445	1,445
25	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	8,744	8,744
26	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(37,236)	(37,236)
27	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	10,011	10,011
28	V						
29	V	17 ADMINISTRATIVE	107,316	S.I.R. MANAGEMENT, INC.	100.00%	29,202	(78,114)
30	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	1,105	
31	V	21 CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	101,027	101,027
32	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	20,618	20,618
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 406,044			\$ 243,670	\$ * (163,479)

* 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%	\$ 7,880	\$ (18,580)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,244	1,244	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	8,138	8,138	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	1,280	1,280	18
19	V	17	ADMIN./LEGAL SALARIES	13,236	S.I.R. MANAGEMENT, INC.	100.00%	85,160	71,924	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	16,341	16,341	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	15,454	15,454	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	26,460	S.I.R. MANAGEMENT, INC.	100.00%	8,525	(17,935)	24
25	V	15	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,348	1,348	25
26	V								26
27	V	6	MAINTENANCE SALARIES	29,693	S.I.R. MANAGEMENT, INC.	100.00%	24,896	(4,797)	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	4,710	4,710	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	2,654	2,654	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	868	868	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	63	63	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	77	77	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	133	133	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	9,518	9,518	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	7,930	7,930	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	4,211	4,211	37
38	V								38
39	Total		\$ 95,849				\$ 200,430	\$ * 104,581	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	39 LEASED EQUIPMENT	24,000	S.I.R. MANAGEMENT, INC.	100.00%		(24,000)	16
17	V	30 DEPRECIATION				10,928	10,928	17
18	V	32 INTEREST				2,273	2,273	18
19	V							19
20	V							20
21	V	19 PROFESSIONAL FEES				(37,472)	(37,472)	21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 24,000			\$ (24,271)	\$ * (48,271)	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	1 Dietary	\$ 20,141	Xcel Supply, LLC	100.00%	\$ 18,799	\$ (1,342)
16	V	3 Housekeeping	83,395	Xcel Supply, LLC	100.00%	77,838	(5,557)
17	V	4 Laundry	946	Xcel Supply, LLC	100.00%	883	(63)
18	V	6 Repairs & Maintenance		Xcel Supply, LLC	100.00%		
19	V	10 Nursing	549,959	Xcel Supply, LLC	100.00%	513,310	(36,649)
20	V	11 Activities		Xcel Supply, LLC	100.00%		
21	V	12 Social Service		Xcel Supply, LLC	100.00%		
22	V	20 Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%		
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%		
24	V	22 Employee Benefits		Xcel Supply, LLC	100.00%		
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%		
26	V	39 Ancillary	80,535	Xcel Supply, LLC	100.00%	75,168	(5,367)
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		\$ 734,976			\$ 685,998	\$ * (48,978)

* 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%	\$ 151,693	\$ 151,693
16	V						
17	V						
18	V						
19	V	22 Employee Health Insurance	151,693	CCS Employee Benefits Group	100.00%		(151,693)
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		\$ 151,693			\$ 151,693	\$ *

* 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	10 Supplies - Enterals	\$ 73,294	Care Centers Health Systems		\$ 41,778	\$ (31,516)
16	V						
17	V						
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		\$ 73,294			\$ 41,778	\$ * (31,516)

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

Facility Name & ID Number

Elmwood Care

0040410

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number

Elmwood Care

0040410

Report Period Beginning:

01/01/10

Ending:

12/31/10

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bryan Barrish	Shareholder	Administrative	14.25	See Attached	3.55	7.89%	Alloc. Salary	\$ 17,729	17-7	1
2	Michael Giannini	Shareholder	Administrative	11.57	See Attached	3.1	7.75%	Alloc. Salary	14,785	17-7	2
3	Sarah Barrish	Relative	Administrative	N/A	See Attached	4.43	8.86%	Alloc. Salary	9,447	17-7	3
4	Kristen Barrish	Relative	Clerical	N/A	See Attached	1.51	8.88%	Alloc. Salary	3,295	21-7	4
5	Nenita Guzman	Relative	Dietary	N/A	See Attached	4.43	8.86%	Alloc. Salary	7,880	1-7	5
6	Louise Bergthold	Shareholder	Administrative	4.94	See Attached	2.48	4.13%	Alloc. Salary	8,645	17-7	6
7	Tom Winter	Shareholder	Administrative	1.44	See Attached	5.32	8.87%	Alloc. Salary	17,729	17-7	7
8	Jeff Oravec	Shareholder	Administrative	0.41	See Attached	3.55	8.88%	Alloc. Salary	11,473	17-7	8
9	Joey Abramchik	Shareholder	Administrative	2.06	See Attached	3.99	8.87%	Alloc. Salary	16,341	17-7	9
10	Elka Abramchick	Relative	Clerical	N/A	See Attached	3.1	8.86%	Alloc. Salary	3,595	21-7	10
11	Adam Vales	Shareholder	Clerical	2.88	See Attached	0.8	2.00%	Alloc. Salary	1,393	22-7	11
12	See second page 7 for the detail of the additional owner and related compensation								13,234		12
13								TOTAL	\$ 125,546		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: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/10

Ending: 12/31/10

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	804,585	12	\$ 159,205	\$ 76,299	71,321	\$ 14,112	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	804,585	12	11,878		71,321	1,053	2
3	10	NURSING	PATIENT DAYS	804,585	12	185,214	185,214	71,321	16,418	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	804,585	12	28,944		71,321	2,566	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	804,585	12	25,021	21,345	71,321	2,218	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	804,585	12	2,832		71,321	251	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	804,585	12	703,778	634,731	71,321	62,385	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	804,585	12	11,977		71,321	1,062	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	804,585	12	98,022		71,321	8,689	9
10	26	INSURANCE	PATIENT DAYS	804,585	12	16,300		71,321	1,445	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	804,585	12	98,638		71,321	8,744	11
12	32	INTEREST	PATIENT DAYS	804,585	12	(420,069)		71,321	(37,236)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	804,585	12	112,938		71,321	10,011	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	804,585	12	329,434	329,434	71,321	29,202	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	804,585	12	12,469		71,321	1,105	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	804,585	12	1,139,702	1,053,550	71,321	101,027	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	804,585	12	232,600		71,321	20,618	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,748,883	\$ 2,300,573		\$ 243,670	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/10

Ending: 12/31/10

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	804,585	12	\$ 88,890	\$ 88,890	71,321	\$ 7,880	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	804,585	12	14,038		71,321	1,244	2
3	10	NURSING SALARIES	PATIENT DAYS	804,585	12	91,810	91,810	71,321	8,138	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	804,585	12	14,444		71,321	1,280	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	804,585	12	960,703	960,703	71,321	85,160	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	804,585	12	184,350		71,321	16,341	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	804,585	12	174,335		71,321	15,454	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	273,888	12	88,247	88,247	26,460	8,525	10
11	15	EMPLOYEE BENEFITS	SPECIAL REHAB INC.	273,888	12	13,949		26,460	1,348	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	322,046	11	270,018	270,018	29,693	24,896	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	322,046	11	51,079		29,693	4,710	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	12	29,926		1,142	2,654	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	12	9,787		1,142	868	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	12	705		1,142	63	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	12	872		1,142	77	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	12	1,497		1,142	133	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	12	107,338		1,142	9,518	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	12	89,427		1,142	7,930	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	12	47,487		1,142	4,211	23
24										24
25	TOTALS					\$ 2,238,902	\$ 1,499,668		\$ 200,430	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/10

Ending: 12/31/10

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	30	DEPRECIATION	LEASING INCOME	100	1	10,928	100	10,928	1
2	32	INTEREST	LEASING INCOME	100	1	2,273	100	2,273	2
3									3
4									4
5	19	PROFESSIONAL FEES	DIRECT ALLOCATION		1	(37,472)	1	(37,472)	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$	\$	(24,271)	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation		\$	\$		18,799	1
2	3	Housekeeping	Direct Allocation					77,838	2
3	4	Laundry	Direct Allocation					883	3
4	6	Repairs & Maintenance	Direct Allocation						4
5	10	Nursing	Direct Allocation					513,310	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					75,168	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				\$	\$		685,998	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/10

Ending: 12/31/10

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		\$	\$		\$ 151,693	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				\$	\$		\$ 151,693	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Care Centers Health Systems

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	10	Supplies - Enterals	Direct Allocation		\$	\$		\$ 41,778	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				\$	\$		\$ 41,778	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Elmwood Care

0040410

Report Period Beginning:

01/01/10

Ending:

12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6	7	8	9	10											
											Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
												YES	NO				Original	Balance			
	A. Directly Facility Related																				
	Long-Term																				
1	Midwest Bank		X	Mortgage			\$	\$ 14,361,962			\$ 974,619	1									
2												2									
3												3									
4												4									
5	See Supplemental Schedule											5									
	Working Capital																				
6	Lake Forest Bank		X	Line of Credit				2,920,000			172,416	6									
7	Partners	X		Loans Payable				900,000				7									
8	See Supplemental Schedule							1,000,000				8									
9	TOTAL Facility Related						\$	\$ 19,181,962			\$ 1,147,035	9									
	B. Non-Facility Related*																				
10	Interest Income		X								(1,468)	10									
11	Interest Income-Bldg Co	X									(6,529)	11									
12	SIR Management	X									(27,033)	12									
13	See Supplemental Schedule											13									
14	TOTAL Non-Facility Related						\$	\$			\$ (35,030)	14									
15	TOTALS (line 9+line14)						\$	\$ 19,181,962			\$ 1,112,005	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:

01/01/10

Ending:

12/31/10

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

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

	1	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
6												6						
7	TOTAL Long-Term																	
	Working Capital																	
8	SIR Management			Note Payable			\$	\$ 1,000,000			\$	8						
9												9						
10												10						
11												11						
12												12						
13												13						
14	TOTAL Working Capital																	
	B. Non-Facility Related*																	
15							\$	\$			\$	15						
16												16						
17												17						
18												18						
19												19						
20	TOTAL Non-Facility Related																	

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

(See instructions.)

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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2009 report.		\$	489,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	525,454	2
3. Under or (over) accrual (line 2 minus line 1).		\$	36,454	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	542,100	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	626	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	579,180	7

Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2005	423,320	8	
	2006	421,217	9	
	2007	468,669	10	
	2008	470,084	11	
	2009	521,243	12	
2009 Accrual= \$521,243 x 1.04= \$542,100				
Alloc. -SIR Management \$4,211				

	FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2009	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/10

Ending:

12/31/10

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR 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
Improvement Type**										
9	Various		1993	129,203		20	6,460	6,460	111,666	9
10	Various		1994	49,738		20	2,487	2,487	41,141	10
11	Various		1995	167,102		20	8,355	8,355	129,800	11
12	Various		1996	136,090		20	6,805	6,805	97,729	12
13	Various		1997	16,180		20	809	809	10,959	13
14	Various		1998	158,155		20	6,538	6,538	108,384	14
15	Various		1999	121,088		20	6,054	6,054	69,822	15
16	Various		2000	67,583		20	3,379	3,379	35,352	16
17	Various		2001	107,654		20	5,383	5,383	51,661	17
18	Various		2002	113,214		20	11,041	11,041	93,822	18
19	Various		2003	145,109		20	7,809	7,809	58,144	19
20	Various		2004	124,757		20	5,954	5,954	41,521	20
21	Various		2005	84,119		20	4,706	4,706	27,435	21
22	Various		2006	127,687		20	6,917	6,917	30,378	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		13,037,673	419,817		428,608	8,791	5,224,073	67
68		146,457	4,367		5,861	1,494	66,261	68
69			107,557			(107,557)		69
70		\$ 14,731,809	\$ 531,741		\$ 517,167	\$ (14,574)	\$ 6,198,148	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning:

01/01/10

Ending:

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 14,731,809	\$ 531,741		\$ 517,167	\$ (14,574)	\$ 6,198,148	1
2	<u>Drapes</u>	2007	5,309		20	531	531	2,124	2
3	<u>Windows</u>	2007	2,847		20	285	285	1,139	3
4	<u>Pipe Insulation</u>	2007	16,426		20	821	821	3,080	4
5	<u>Pipe Insulation</u>	2007	5,636		20	282	282	1,057	5
6	<u>Exhaust Fans</u>	2007	2,596		20	260	260	909	6
7	<u>Boiler Work</u>	2007	2,763		20	138	138	553	7
8	<u>Concrete And Sewer</u>	2007	2,200		20	110	110	422	8
9	<u>Mixing Valves</u>	2007	3,800		20	190	190	728	9
10	<u>Cable/Phone Wire</u>	2007	1,717		20	86	86	329	10
11	<u>Cable/Phone Wire</u>	2007	3,864		20	193	193	741	11
12	<u>Fire Alarm System</u>	2007	9,235		20	462	462	1,732	12
13	<u>Low Pressure Alarms</u>	2007	2,823		20	141	141	518	13
14	<u>Hvac Work</u>	2007	10,564		20	528	528	1,937	14
15	<u>Ejector Pump</u>	2007	1,563		20	156	156	521	15
16	<u>Chemical Pump</u>	2007	2,051		20	205	205	684	16
17	<u>Electrical Work</u>	2007	4,868		20	243	243	791	17
18	<u>Flooring</u>	2007	12,751		20	638	638	2,072	18
19	<u>Low Air Loss Alarm</u>	2007	7,058		20	706	706	2,294	19
20	<u>Hot Water Valve</u>	2007	2,188		20	219	219	711	20
21	<u>Low Air Loss Alarm</u>	2007	5,646		20	565	565	1,788	21
22	<u>Boiler</u>	2007	1,863		20	186	186	590	22
23	<u>Electrical Work</u>	2007	3,877		20	194	194	598	23
24	<u>Sewer Pump</u>	2007	5,300		20	265	265	861	24
25	<u>Fire Doors</u>	2007	2,860		20	143	143	441	25
26	<u>Fire Doors</u>	2007	4,183		20	209	209	645	26
27	<u>2008 Audit Adjustment 2007</u>	2007	(12,836)		20	(1,284)	(1,284)	(3,958)	27
28	<u>Cubicle Curtains</u>	2007	3,261		20	163	163	625	28
29	<u>Alarm System</u>	2007	2,767		20	138	138	484	29
30	<u>Boiler Work</u>	2008	10,825		20	541	541	1,624	30
31	<u>Fire Door</u>	2008	2,460		20	123	123	308	31
32	<u>Curtains</u>	2008	10,230		20	512	512	1,236	32
33	<u>Flooring - Vinyl Rock / Gridstone Tiles</u>	2008	3,320		20	166	166	374	33
34	TOTAL (lines 1 thru 33)		\$ 14,875,824	\$ 531,741		\$ 525,282	\$ (6,459)	\$ 6,226,101	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:

01/01/10

Ending:

12/31/10

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 14,875,824	\$ 531,741		\$ 525,282	\$ (6,459)	\$ 6,226,101	1
2	Surveillance System	2008	3,424		20	171	171	385	2
3	Flooring - Vinyl	2008	4,400		20	220	220	495	3
4	Ejector Pump, Boiler, 7 Exhaust	2008	2,909		20	145	145	388	4
5	Sprinkler System	2008	6,566		20	328	328	739	5
6	Elevator Tracks	2008	7,056		20	353	353	882	6
7	Ejector Pumps / Piping	2008	5,323		20	266	266	776	7
8	Hvac Work	2009	10,548		20	527	527	1,055	8
9	Exhaust Fans	2009	11,567		20	578	578	1,157	9
10	Whirlpool Tub	2009	8,899		20	445	445	816	10
11	Boiler Room Dampers	2009	4,983		20	249	249	436	11
12	Parking Lot	2009	37,500		20	1,875	1,875	2,813	12
13	Security System	2009	2,948		20	295	295	393	13
14	Outdoor Storage Building	2009	5,118		20	256	256	267	14
15	Outdoor Storage Building	2009	3,058		20	153	153	159	15
16	Window Treatments	2009	7,260		20	363	363	393	16
17	Walk-In Cooler Work	2009	9,538		20	477	477	874	17
18	Water Heater Repair	2009	4,125		20	206	206	378	18
19	Chiller Start-Up	2009	2,995		20	150	150	250	19
20	Rod Floor Drains	2009	3,056		20	153	153	255	20
21	Sprinkler Repair	2009	3,661		20	183	183	351	21
22	Painting	2010	6,150		20	308	308	308	22
23	Ventilator Alarm	2010	19,250		20	722	722	722	23
24	Fence And Gate	2010	3,374		20	127	127	127	24
25	Ceiling Tile	2010	16,935		20	494	494	494	25
26	Dialysis Renovation	2010	149,735		20	4,367	4,367	4,367	26
27	Fire Stopping	2010	7,000		20	117	117	117	27
28	Office Carpet	2010	3,496		20	146	146	146	28
29	Cubicle Curtains	2010	3,369		20	168	168	168	29
30	Lobby Drapes	2010	7,133		20	297	297	297	30
31	Alarm System	2010	3,155		20	131	131	131	31
32	Boiler Work	2010	14,408		20	600	600	600	32
33	Custom Woodwork	2010	19,780		20	659	659	659	33
34	TOTAL (lines 1 thru 33)		\$ 15,274,543	\$ 531,741		\$ 540,813	\$ 9,072	\$ 6,247,498	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:

01/01/10

Ending:

12/31/10

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 15,274,543	\$ 531,741		\$ 540,813	\$ 9,072	\$ 6,247,498	1
2	Trash Chute	2010	2,752		20	92	92	92	2
3	Walk-In Cooler Work	2010	4,841		20	242	242	242	3
4	Replace Wallpaper	2010	2,600		20	130	130	130	4
5	Startup Chiller	2010	4,547		20	227	227	227	5
6	Replace Locks	2010	3,181		20	159	159	159	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)		\$ 15,292,463	\$ 531,741		\$ 541,663	\$ 9,922	\$ 6,248,348	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		\$ 15,292,463	\$ 531,741		\$ 541,663	\$ 9,922	\$ 6,248,348	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)	\$ 15,292,463	\$ 531,741		\$ 541,663	\$ 9,922	\$ 6,248,348	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:

01/01/10

Ending:

12/31/10

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	Building Company Information								1
2	Buildings:								2
3		1975	10,419,509	419,817	35	297,700	(122,117)	4,868,649	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	HVAC Project	2008	1,560,000		20	78,000	78,000	234,000	9
10	Painting	2008	130,000		20	6,500	6,500	19,500	10
11	Elevator Cab	2008	43,612		20	2,181	2,181	6,543	11
12	Concrete Patio	2008	2,200		20	110	110	330	12
13	Hand Rails	2008	15,105		20	755	755	2,265	13
14	Nurse Station	2008	112,920		20	5,646	5,646	16,938	14
15	Side Entry Hub	2008	8,245		20	412	412	1,236	15
16	Nurses Stations	2009	37,640		20	1,882	1,882	3,764	16
17	Window Treatment	2009	6,775		20	339	339	678	17
18	1st Floor Tile	2009	126,810		20	6,341	6,341	12,682	18
19	Resident Bathroom/Dayroom - Ceiling, Fixtures, Tiles, Paint	2009	202,085		20	10,104	10,104	20,208	19
20	Wiring	2009	22,534		20	1,127	1,127	2,254	20
21	Windows	2009	3,200		20	160	160	320	21
22	Lower Level Mall-Ceiling, Plumbing, Doors, Paint	2009	201,263		20	10,063	10,063	20,126	22
23	Painting	2009	15,000		20	750	750	1,500	23
24	Lower Level Mall-Drawings for Construction Permit	2009	9,000		20	450	450	900	24
25	2nd Floor Work	2009	23,400		20	1,170	1,170	2,340	25
26	2nd Floor Ceiling	2009	16,070		20	804	804	1,608	26
27	Sprinkler System Renovation	2009	11,017		20	551	551	1,102	27
28	Chair rail in dining Room	2009	11,312		20	566	566	1,132	28
29	Handrails - Floors 2,3,4	2009	44,652		20	2,233	2,233	4,466	29
30	Wallbase - Floors 2,3,4	2009	15,324		20	766	766	1,532	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:

01/01/10

Ending:

12/31/10

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 (12F & 12G lines 1 thru 33)	\$ 13,037,673	\$ 419,817		\$ 428,608	\$ 8,791	\$ 5,224,073	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:

01/01/10

Ending:

12/31/10

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	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	SIR Properties- SIR Management	1993	40,138	1,274	35	1,147	(127)	20,069	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	S.I.R. Properties- S.I.R. Management- Allocation	2010	2,422		20	40	40	40	9
10	S.I.R. Properties- S.I.R. Management- Allocation	2009	2,410	295	20	121	(174)	217	10
11	S.I.R. Properties- S.I.R. Management- Allocation	2007	703	76	20	35	(41)	141	11
12	S.I.R. Properties- S.I.R. Management- Allocation	2002	159		20	8	8	68	12
13	S.I.R. Properties- S.I.R. Management- Allocation	1999	5,086		20	254	254	2,924	13
14	S.I.R. Properties- S.I.R. Management- Allocation	1998	2,431		20	122	122	1,519	14
15	S.I.R. Properties- S.I.R. Management- Allocation	1997	151		20	8	8	110	15
16	S.I.R. Properties- S.I.R. Management- Allocation	1994	382	10	20	19	9	315	16
17	S.I.R. Properties- S.I.R. Management- Allocation	1993	651	3	20	33	30	570	17
18									18
19	S.I.R. Management- Allocation	1993	10,176	283	20	505	222	9,081	19
20	S.I.R. Management- Allocation	1994	32		20			32	20
21	S.I.R. Management- Allocation	1995	233		20	12	12	179	21
22	S.I.R. Management- Allocation	1997	15,637	350	20	782	432	10,796	22
23	S.I.R. Management- Allocation	1999	1,229		20	62	62	691	23
24	S.I.R. Management- Allocation	1999	13,707		20			13,707	24
25	S.I.R. Management- Allocation	2000	1,452		20	73	73	765	25
26	S.I.R. Management- Allocation	2007	4,664	499	20	233	(266)	745	26
27	S.I.R. Management- Allocation	2008	12,854	1,285	20	810	(475)	2,305	27
28	S.I.R. Management- Allocation	2009	31,940	292	20	1,597	1,305	1,987	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.

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)		\$ 146,457	\$ 4,367		\$ 5,861	\$ 1,494	\$ 66,261	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:

01/01/10

Ending:

12/31/10

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	\$ 1,368,994	\$ 4,829	\$ 116,612	\$ 111,783	10	\$ 631,723	71
72	Current Year Purchases	450,113	11,072	32,370	21,298	10	66,986	72
73	Fully Depreciated Assets	1,216,638		70	70	10	1,216,638	73
74								74
75	TOTALS	\$ 3,035,745	\$ 15,901	\$ 149,051	\$ 133,150		\$ 1,915,347	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		Allocated-SIR Management	2010	\$ 2,350	\$ 176	\$ 176	\$	5	\$ 176	76
77										77
78										78
79										79
80	TOTALS			\$ 2,350	\$ 176	\$ 176	\$		\$ 176	80

E. Summary of Care-Related Assets

	1	2		
	Reference	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)	\$ 19,055,549	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 547,818	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 690,890	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 143,072	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,163,871	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: \$ 18,082 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. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	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					\$ 268,598							\$ 268,598	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					169,155							169,155	2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39 - 03	hrs					322,734							322,734	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							301,647					301,647	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															12
13	Other (specify): <u>See Supplemental</u>				906,697			339,669		468,927					1,715,293	13
14	TOTAL				\$ 906,697			\$ 1,100,156		\$ 770,574					\$ 2,777,427	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: 01/01/10Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 46,668	\$ 1,073,325	1
2	Cash-Patient Deposits	82,188	82,188	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,123,115	3,123,115	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	92,977	92,977	6
7	Other Prepaid Expenses	59,484	24,484	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>		130,807	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,404,432	\$ 4,526,896	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		727,991	13
14	Buildings, at Historical Cost		10,419,509	14
15	Leasehold Improvements, at Historical Cost	992,289	3,610,453	15
16	Equipment, at Historical Cost	2,546,813	3,902,923	16
17	Accumulated Depreciation (book methods)	(2,100,719)	(7,806,269)	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>		66,409	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,438,383	\$ 10,921,016	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,842,815	\$ 15,447,912	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,066,753	\$ 1,344,373	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	82,435	82,435	28
29	Short-Term Notes Payable	3,820,000	3,820,000	29
30	Accrued Salaries Payable	411,583	411,583	30
31	Accrued Taxes Payable (excluding real estate taxes)	107,476	107,476	31
32	Accrued Real Estate Taxes(Sch.IX-B)		542,100	32
33	Accrued Interest Payable		52,361	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,488,247	\$ 6,360,328	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		1,000,000	39
40	Mortgage Payable		14,361,962	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 15,361,962	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,488,247	\$ 21,722,290	46
47	TOTAL EQUITY(page 18, line 24)	\$ (645,432)	\$ (6,274,378)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,842,815	\$ 15,447,912	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (654,243)	1
2	Restatements (describe):		2
3	<u>Rounding</u>	6	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (654,237)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	8,805	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 8,805	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (645,432)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care# 0040410Report Period Beginning: 01/01/10Ending: 12/31/10

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 13,194,182	1
2	Discounts and Allowances for all Levels	(926,836)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,267,346	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,156,630	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,156,630	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	346,088	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	23,573	19
20	Radiology and X-Ray	12,252	20
21	Other Medical Services	659,042	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,040,955	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,468	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,468	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	562,468	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 562,468	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,028,867	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,190,143	31
32	Health Care	5,714,059	32
33	General Administration	3,007,953	33
B. Capital Expense			
34	Ownership	2,172,044	34
C. Ancillary Expense			
35	Special Cost Centers	2,801,725	35
36	Provider Participation Fee	134,138	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 16,020,062	40
41	Income before Income Taxes (line 30 minus line 40)**	8,805	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 8,805	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:

01/01/10

Ending:

12/31/10

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	2,037	2,086	\$ 106,229	\$ 50.92	1
2	Assistant Director of Nursing	1,941	2,200	83,074	37.76	2
3	Registered Nurses	38,775	40,728	1,215,198	29.84	3
4	Licensed Practical Nurses	44,933	47,618	1,262,742	26.52	4
5	CNAs & Orderlies	117,076	122,964	1,359,585	11.06	5
6	CNA Trainees					6
7	Licensed Therapist	38,164	40,167	906,697	22.57	7
8	Rehab/Therapy Aides	8,235	8,829	219,981	24.92	8
9	Activity Director	1,869	2,086	33,663	16.14	9
10	Activity Assistants	8,969	9,451	86,707	9.17	10
11	Social Service Workers	13,290	14,536	235,459	16.20	11
12	Dietician					12
13	Food Service Supervisor	3,530	3,826	66,593	17.41	13
14	Head Cook	6,409	7,004	74,830	10.68	14
15	Cook Helpers/Assistants	20,745	22,692	224,283	9.88	15
16	Dishwashers					16
17	Maintenance Workers	6,706	7,274	99,616	13.69	17
18	Housekeepers	28,039	30,338	283,460	9.34	18
19	Laundry	10,031	10,742	98,074	9.13	19
20	Administrator	2,580	2,960	159,976	54.05	20
21	Assistant Administrator	3,388	3,685	85,625	23.24	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,292	10,544	140,828	13.36	24
25	Vocational Instruction	530	530	2,150	4.06	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	8,008	8,669	158,134	18.24	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,819	3,088	52,417	16.97	33
34	TOTAL (lines 1 - 33)	378,366	402,017	\$ 6,955,321 *	\$ 17.30	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	\$ 34,999	01-03	35
36	Medical Director	Monthly	13,800	09-03	36
37	Medical Records Consultant	Monthly	4,416	10-03	37
38	Nurse Consultant	1,323	52,920	10-03	38
39	Pharmacist Consultant	Monthly	12,642	10-03	39
40	Physical Therapy Consultant	29	1,961	10a-03	40
41	Occupational Therapy Consultant	20	1,376	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	510	21,987	10a-03	43
44	Activity Consultant	Monthly	2,448	11-03	44
45	Social Service Consultant	92	4,792	12-03	45
46	Other(specify)				46
47	Director of Food Services	Monthly	26,460	01-03	47
48	Specialized Rehab Consultant	Monthly	26,460	10-03	48
49	TOTAL (lines 35 - 48)	1,974	\$ 204,261		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			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)		\$	53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care

0040410

Report Period Beginning: 01/01/10

Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Arleen Manchavez-Siap	Administrator	0%	\$ 108,969	Workers' Compensation Insurance	\$ 167,405	IDPH License Fee	\$ 992		
Mark Solomon	Administrator	0%	51,007	Unemployment Compensation Insurance	50,249	Advertising: Employee Recruitment	22,589		
Kelly Iannelli	Assist. Admin	0%	11,843	FICA Taxes	524,166	Health Care Worker Background Check			
Monique Jones-Stafford	Assist. Admin	0%	12,623	Employee Health Insurance	221,182	(Indicate # of checks performed <u>212</u>)	4,595		
Irma Olson	Assist. Admin	0%	61,158	Employee Meals	43,844	Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Advertising	41,349		
				Pension Plan	47,185	Dues & Subscriptions	14,471		
				401K Contribution	8,200	Licenses and Permits	8,641		
				Employee Benefits-Other	11,503	Alloc.- SIR Management	251		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)									
			\$ 245,600						
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
S.I.R. Management- Dir. Of Administrative Services			\$ 52,920				Out-of-State Travel	\$	
S.I.R. Management- Ancillary Charges			54,396						
S.I.R. Management- Owner's Council			13,236				In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
			\$ 120,552			\$ 1,073,733	\$ 51,539		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description	Amount	
Frost, Ruttenberg & Rothblatt	Accounting	\$ 24,455							
S.I.R. Management	Accounting	36,000							
S.I.R. Management	Dir. Of Regulatory Serv.	26,460							
S.I.R. Management	Bookkeeping	102,888							
Personal Planners	Unemployment Tax Consult	3,178							
E-Health Data Solutions	Data Processing	3,600							
Pinnacle Consulting	Cust. Satisfaction Survey	2,090							
Amari & Locallo	RE Tax Appeal	250							
Patient Systems	Software Subscription Fee	3,900					Seminar Expense	5,096	
Honkemp Kruegar	Tax Credit Programs	5					Alloc. SIR Management	1,062	
Hamlin & Burton	Liability Management	1,000							
See Supplemental Schedule		52,034							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL				Entertainment Expense (agree to Sch. V, line 24, col. 8)	
			\$ 255,860			\$	TOTAL	\$ 6,158	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care# 0040410Report Period Beginning: 01/01/10Ending: 12/31/10**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- \$19,411.35; 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. \$ 10,561 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 134,138
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 43,844 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? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) 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.