FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0031971

Facility Name: Greenwood Care

Address: 1406 Chicago Avenue (Number) Evanston (City) 60201 (Zip Code)

County: Cook

Telephone Number: (847) 328-7508 **Fax #** (847) 869-4878

HFS ID Number:

Date of Initial License for Current Owners: 01/01/1990

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Cary Drazner, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	145	Intermediate (ICF)	145	52,925	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	145	TOTALS	145	52,925	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	47,516	873		48,389	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,516	873		48,389	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.43%

D. How many bed-hold days during this year were paid by the Department?
1,866 (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)
N/A

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 02/01/1987

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/1978 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	182,429	21,030	24,716	228,175		228,175	(10,314)	217,861			1
2	Food Purchase		234,694		234,694	(18,907)	215,787	(42)	215,745			2
3	Housekeeping	198,077	30,443		228,520		228,520	(1,576)	226,944			3
4	Laundry		12,088	11,587	23,675		23,675		23,675			4
5	Heat and Other Utilities			107,695	107,695		107,695	1,801	109,496			5
6	Maintenance	45,359	39,617	187,078	272,054		272,054	(23,864)	248,190			6
7	Other (specify):*							11,707	11,707			7
8	**TOTAL General Services**	425,865	337,872	331,076	1,094,813	(18,907)	1,075,906	(22,288)	1,053,618			8
	B. Health Care and Programs											
9	Medical Director			7,800	7,800		7,800		7,800			9
10	Nursing and Medical Records	1,139,065	36,757	101,037	1,276,859		1,276,859	(17,102)	1,259,757			10
10a	Therapy			15,660	15,660		15,660	(10,614)	5,046			10a
11	Activities	171,617	14,235	4,355	190,207		190,207		190,207			11
12	Social Services	223,560			223,560		223,560		223,560			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							3,408	3,408			15
16	**TOTAL Health Care and Programs**	1,534,242	50,992	128,852	1,714,086		1,714,086	(24,308)	1,689,778			16
	C. General Administration											
17	Administrative	82,223		447,306	529,529		529,529	(369,715)	159,814			17
18	Directors Fees											18
19	Professional Services			149,884	149,884	(2,956)	146,928	(101,307)	45,621			19
20	Dues, Fees, Subscriptions & Promotions			56,946	56,946		56,946	(34,727)	22,219			20
21	Clerical & General Office Expenses	171,433	36,564	74,239	282,236		282,236	57,322	339,558			21
22	Employee Benefits & Payroll Taxes			402,471	402,471	18,907	421,378		421,378			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,783	2,783		2,783	720	3,503			24
25	Other Admin. Staff Transportation			5,577	5,577		5,577	5,895	11,472			25
26	Insurance-Prop.Liab.Malpractice			114,209	114,209		114,209	7,641	121,850			26
27	Other (specify):*							30,406	30,406			27
28	**TOTAL General Administration**	253,656	36,564	1,253,415	1,543,635	15,951	1,559,586	(403,765)	1,155,821			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,213,763	425,428	1,713,343	4,352,534	(2,956)	4,349,578	(450,361)	3,899,217			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 Greenwood Care #0031971 Report Period Beginning: 01/01/10 Ending: 12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			49,737	49,737		49,737	251,065	300,802			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,512	27,512		27,512	557,696	585,208			32
33	Real Estate Taxes					2,956	2,956	137,478	140,434			33
34	Rent-Facility & Grounds			978,000	978,000		978,000	(978,000)				34
35	Rent-Equipment & Vehicles			6,359	6,359		6,359	6,792	13,151			35
36	Other (specify):*							120,319	120,319			36
37	**TOTAL Ownership**			1,061,608	1,061,608	2,956	1,064,564	95,350	1,159,914			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			79,388	79,388		79,388		79,388			42
43	Other (specify):*			333	333		333	(333)				43
44	**TOTAL Special Cost Centers**			79,721	79,721		79,721	(333)	79,388			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,213,763	425,428	2,854,672	5,493,863		5,493,863	(355,344)	5,138,519			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	107,451	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(42)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(10,000)	20		18
19	Entertainment				19
20	Contributions	(9,368)	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	(14,349)	21		24
25	Fund Raising, Advertising and Promotional	(3,421)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(49)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(88,508)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (18,286)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 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)	(337,058)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (337,058)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (355,344)		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 Yes	2 No	3 Amount	4 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

SEE ACCOUNTANTS' COMPILATION REPORT

Greenwood Care

ID# 0031971

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Fees	$ (5,795)	21	1
2	Theft & Damage	(2,086)	21	2
3	Non-allowable Legal	(1,393)	19	3
4	COPE Dues	(4,663)	20	4
5	Alliance for Living - PAC Dues	(7,445)	20	5
6	Interest Income - Shareholder Interest	(5,747)	32	6
7	Prior Period Nursing Expense	(451)	10	7
8	Prior Period Expense - R&M	(16,153)	06	8
9	Marketing Expense	(333)	43	9
10				10
11				11
12	Building Company:			12
13	Fees	(150)	21	13
14	Filing Fees	(350)	21	14
15	Office Expense	(3)	21	15
16	Amortization	(4,041)	36	16
17	Replacement Tax	(642)	21	17
18	Disallowed R&M	(9,988)	06	18
19	Capitalized R&M	(29,268)	06	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**	(88,508)		49

Greenwood Care

ID# 0031971

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 Greenwood Care # 0031971 **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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(10,314)								(10,314)	1
2	Food Purchase	(42)											(42)	2
3	Housekeeping					(1,576)							(1,576)	3
4	Laundry													4
5	Heat and Other Utilities				1,801								1,801	5
6	Maintenance	(55,409)	47,378	(6,085)	(9,748)								(23,864)	6
7	Other (specify):*			714	10,993								11,707	7
8	**TOTAL General Services**	(55,451)	47,378	(5,371)	(7,268)	(1,576)							(22,288)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(451)		(20,181)	5,522	(1,992)							(17,102)	10
10a	Therapy				(10,614)								(10,614)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			1,741	1,667								3,408	15
16	**TOTAL Health Care and Programs**	(451)		(18,440)	(3,425)	(1,992)							(24,308)	16
	C. General Administration													
17	Administrative			(419,657)	49,942								(369,715)	17
18	Directors Fees													18
19	Professional Services	(1,393)		(111,043)	11,129								(101,307)	19
20	Fees, Subscriptions & Promotions	(34,897)		170									(34,727)	20
21	Clerical & General Office Expenses	(23,424)	1,145	79,549	52								57,322	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			720									720	24
25	Other Admin. Staff Transportation			5,895									5,895	25
26	Insurance-Prop.Liab.Malpractice		6,571	980	90								7,641	26
27	Other (specify):*			19,921	10,485								30,406	27
28	**TOTAL General Administration**	(59,714)	7,716	(423,465)	71,698								(403,765)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(115,616)	55,094	(447,276)	61,005	(3,568)							(450,361)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Greenwood Care # 0031971 **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 D. Ownership	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)	
30	Depreciation	107,451	137,155		6,459								251,065	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(5,747)	583,326	(25,264)	5,381								557,696	32
33	Real Estate Taxes		134,620		2,858								137,478	33
34	Rent-Facility & Grounds		(978,000)										(978,000)	34
35	Rent-Equipment & Vehicles			6,792									6,792	35
36	Other (specify):*	(4,041)	124,360										120,319	36
37	**TOTAL Ownership**	97,663	1,461	(18,472)	14,698								95,350	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(333)											(333)	43
44	**TOTAL Special Cost Centers**	(333)											(333)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(18,286)	56,555	(465,748)	75,703	(3,568)							(355,344)	45

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/10 Ending: 12/31/10

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		
				Greenwood Care,	Evanston	Building Co.
				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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 978,000	Greenwood Care, LLC	100.00%	$	$ (978,000)	1
2	V	32	Interest Income	446	Greenwood Care, LLC	100.00%		(446)	2
3	V	36	Amortization of HUD Fees		Greenwood Care, LLC	100.00%	4,041	4,041	3
4	V	06	Building R&M		Greenwood Care, LLC	100.00%	37,380	37,380	4
5	V	30	Depreciation		Greenwood Care, LLC	100.00%	137,155	137,155	5
6	V	06	Decorating Costs		Greenwood Care, LLC	100.00%	9,998	9,998	6
7	V	21	Fees & Filing Fees		Greenwood Care, LLC	100.00%	500	500	7
8	V	32	Mortgage Interest		Greenwood Care, LLC	100.00%	583,772	583,772	8
9	V	36	Mortgage Insurance		Greenwood Care, LLC	100.00%	120,319	120,319	9
10	V	21	Office Expense		Greenwood Care, LLC	100.00%	3	3	10
11	V	26	Property Insurance		Greenwood Care, LLC	100.00%	6,571	6,571	11
12	V	33	Real Estate Taxes		Greenwood Care, LLC	100.00%	134,620	134,620	12
13	V	21	Replacement Tax		Greenwood Care, LLC	100.00%	642	642	13
14	Total			$ 978,446			$ 1,035,001	$ * 56,555	14

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

Facility Name & ID Number Greenwood Care # 0031971 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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS AND MAINT.	$ 15,660	S.I.R. MANAGEMENT, INC.	100.00%	$ 9,575	$ (6,085)	15
16	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	714	714	16
17	V	10	NURSING	31,320	S.I.R. MANAGEMENT, INC.	100.00%	11,139	(20,181)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	1,741	1,741	18
19	V	19	PROFESSIONAL FEES	112,548	S.I.R. MANAGEMENT, INC.	100.00%	1,505	(111,043)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	170	170	20
21	V	21	CLERICAL & GENERAL	31,320	S.I.R. MANAGEMENT, INC.	100.00%	42,326	11,006	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	720	720	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	5,895	5,895	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	980	980	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	5,932	5,932	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(25,264)	(25,264)	26
27	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	6,792	6,792	27
28	V								28
29	V	17	ADMINISTRATIVE	439,470	S.I.R. MANAGEMENT, INC.	100.00%	19,813	(419,657)	29
30	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	750		30
31	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	68,543	68,543	31
32	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	13,989	13,989	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 630,318			$ 165,320	$ * (465,748)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 15,660	S.I.R. MANAGEMENT, INC.	100.00%	$ 5,346	$ (10,314)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	844	844	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	5,522	5,522	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	869	869	18
19	V	17	ADMIN./LEGAL SALARIES	7,836	S.I.R. MANAGEMENT, INC.	100.00%	57,778	49,942	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	11,087	11,087	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	10,485	10,485	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	15,660	S.I.R. MANAGEMENT, INC.	100.00%	5,046	(10,614)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	798	798	25
26	V								26
27	V	6	MAINTENANCE SALARIES	63,986	S.I.R. MANAGEMENT, INC.	100.00%	53,649	(10,337)	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	10,149	10,149	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	1,801	1,801	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	589	589	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	42	42	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	52	52	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	90	90	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	6,459	6,459	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	5,381	5,381	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	2,858	2,858	37
38	V								38
39	Total			$ 103,142			$ 178,845	$ * 75,703	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Xcel Supply, LLC	100.00%	$	$	15
16	V	3	Housekeeping	23,658	Xcel Supply, LLC	100.00%	22,082	(1,576)	16
17	V	4	Laundry		Xcel Supply, LLC	100.00%			17
18	V	6	Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10	Nursing	29,887	Xcel Supply, LLC	100.00%	27,895	(1,992)	19
20	V	11	Activities		Xcel Supply, LLC	100.00%			20
21	V	12	Social Service		Xcel Supply, LLC	100.00%			21
22	V	20	Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21	Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22	Employee Benefits		Xcel Supply, LLC	100.00%			24
25	V	24	Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39	Ancillary		Xcel Supply, LLC	100.00%			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			$ 53,545			$ 49,977	$ * (3,568)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 125,521	$ 125,521	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	125,521	CCS Employee Benefits Group	100.00%		(125,521)	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			$ 125,521			$ 125,521	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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 Greenwood Care # 0031971 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Michael Giannini	Owner	Administrative	3.45%	See Attached	2.1	5.25%	Alloc. Salary	$ 10,031	17-7	1
2	Bryan Barrish	Owner	Administrative	15.52%	See Attached	2.41	5.36%	Alloc. Salary	12,028	17-7	2
3	Kristen Barrish	Relative	Clerical	N/A	See Attached	1.02	6.00%	Alloc. Salary	2,235	21-7	3
4	Sarah Barrish	Relative	Administrative	N/A	See Attached	3.01	6.02%	Alloc. Salary	6,409	17-7	4
5	Nenita Guzman	Relative	Dietary	N/A	See Attached	3.01	6.02%	Alloc. Salary	5,346	1-7	5
6	Louise Bergthold	Owner	Administrative	3.45%	See Attached	1.68	2.80%	Alloc. Salary	5,865	17-7	6
7	Tom Winter	Owner	Administrative	4.14%	See Attached	3.61	6.02%	Alloc. Salary	12,028	17-7	7
8	Adam Vales	Relative	Clerical	0.00%	See Attached	0.66	1.65%	Alloc. Salary	1,153	22-7	8
9	G. Matt Silvers	Relative	Administrative	0.00%	See Attached	0.27	1.21%	Alloc. Salary	907	17-7	9
10	Eric Rothner	Shareholder	Administrative	51.72%	See Attached	0.36	0.77%	Alloc. Salary	6,014	17-7	10
11	*** Where applicable, the amounts reported on this page have been adjusted from the actual costs										11
12	to reflect costs to reflect only amounts anticipated to be considered allowable by the IL Dept of HFS										12
13								TOTAL	$ 62,016		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

Facility Name & ID Number Greenwood Care # 0031971 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 [X]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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 Greenwood Care # 0031971 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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	REPAIRS AND MAINT.	PATIENT DAYS	804,585	12	$ 159,205	$ 76,299	48,389	$ 9,575	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	804,585	12	11,878		48,389	714	2
3	10	NURSING	PATIENT DAYS	804,585	12	185,214	185,214	48,389	11,139	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	804,585	12	28,944		48,389	1,741	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	804,585	12	25,021	21,345	48,389	1,505	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	804,585	12	2,832		48,389	170	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	804,585	12	703,778	634,731	48,389	42,326	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	804,585	12	11,977		48,389	720	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	804,585	12	98,022		48,389	5,895	9
10	26	INSURANCE	PATIENT DAYS	804,585	12	16,300		48,389	980	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	804,585	12	98,638		48,389	5,932	11
12	32	INTEREST	PATIENT DAYS	804,585	12	(420,069)		48,389	(25,264)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	804,585	12	112,938		48,389	6,792	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	804,585	12	329,434	329,434	48,389	19,813	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	804,585	12	12,469		48,389	750	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	804,585	12	1,139,702	1,053,550	48,389	68,543	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	804,585	12	232,600		48,389	13,989	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,748,883	$ 2,300,573		$ 165,320	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	804,585	12	$ 88,890	$ 88,890	48,389	$ 5,346	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	804,585	12	14,038		48,389	844	2
3	10	NURSING SALARIES	PATIENT DAYS	804,585	12	91,810	91,810	48,389	5,522	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	804,585	12	14,444		48,389	869	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	804,585	12	960,703	960,703	48,389	57,778	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	804,585	12	184,350		48,389	11,087	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	804,585	12	174,335		48,389	10,485	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	273,888	12	88,247	88,247	15,660	5,046	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	273,888	12	13,949		15,660	798	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	322,046	11	270,018	270,018	63,986	53,649	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	322,046	11	51,079		63,986	10,149	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	12	29,926		775	1,801	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	12	9,787		775	589	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	12	705		775	42	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	12	872		775	52	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	12	1,497		775	90	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	12	107,338		775	6,459	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	12	89,427		775	5,381	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	12	47,487		775	2,858	23
24										24
25	TOTALS					$ 2,238,902	$ 1,499,668		$ 178,845	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation			$	$		$	1
2	3	Housekeeping	Direct Allocation						22,082	2
3	4	Laundry	Direct Allocation							3
4	6	Repairs & Maintenance	Direct Allocation							4
5	10	Nursing	Direct Allocation						27,895	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							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					$	$		$ 49,977	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 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 [X] NO [ ]

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

Name of Related Organization: CCS Employee Benefits Group, Inc.
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation			$	$		$ 125,521	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					$	$		$ 125,521	25

Facility Name & ID Number Greenwood Care # 0031971 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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 Greenwood Care # 0031971 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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 Greenwood Care # 0031971 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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

Facility Name & ID Number Greenwood Care # 0031971 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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

Facility Name & ID Number Greenwood Care # 0031971 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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

Facility Name & ID Number Greenwood Care # 0031971 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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	The Private Bank		X				$	$ 12,139,520			$ 583,772	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Lake Forest Bank		X	Line of Credit				525,000			21,765	6
7	SIR Management Allocation		X								(19,883)	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 12,664,520			$ 585,654	9
	B. Non-Facility Related*											
10	Interest Income		X								(0)	10
11	Interest Income - Bldg Co		X								(446)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (446)	14
15	TOTALS (line 9+line14)						$	$ 12,664,520			$ 585,208	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ 120,319 Line # 36**

*** 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 Greenwood Care # 0031971 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	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

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 Greenwood Care # 0031971 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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.	$	123,000	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.)	$	128,478	2
3. Under or (over) accrual (line 2 minus line 1).	$	5,478	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	132,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.	$	2,956	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.	$	140,434	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	119,367	8
	2006	121,402	9
	2007	113,003	10
	2008	117,342	11
	2009	125,620	12

2010 Accrual = $125,620 x 1.05 = $132,000

S.I.R. Management Allocation = $2,858

	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Greenwood Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0031971

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-18-324-019-0000	Long Term Care Property	$ 125,619.57	$ 125,619.57
2.	See Attached	See Attached	$ 80,891.59	$ 3,812.16
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 206,511.16	$ 129,431.73

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Greenwood Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0031971

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

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

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original second installment tax bill.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,647 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 7

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility - Greenwood Care LLC		1987	$ 152,555	1
2					2
3	TOTALS			$ 152,555	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1984	2,672		20	76	76	1,878	9
10	Various			1987	24,869		20	694	694	17,734	10
11	Various			1988	27,733		20	321	321	19,035	11
12	Various			1989	7,668		20	87	87	5,419	12
13	Various			1990	9,800		20	339	339	9,235	13
14	Various			1992	25,025		20	982	982	23,474	14
15	Various			1993	63,911		20	3,193	3,193	56,722	15
16	Various			1994	20,319		20	1,016	1,016	16,652	16
17	Various			1995	73,839		20	3,692	3,692	57,568	17
18	Various			1996	109,220		20	5,461	5,461	79,465	18
19	Various			1997	73,171		20	3,659	3,659	49,412	19
20	Various			1998	58,371		20	2,919	2,919	36,420	20
21	Various			1999	179,834		20	9,098	9,098	104,736	21
22	Various			2000	171,876		20	8,594	8,594	92,028	22
23	Various			2001	43,730		20	2,187	2,187	21,531	23
24	Various			2002	87,606		20	5,329	5,329	45,267	24
25	Various			2003	59,109		20	4,204	4,204	30,489	25
26	Various			2004	77,107		20	4,569	4,569	30,348	26
27	Various			2005	58,861		20	3,273	3,273	17,784	27
28	Various			2006	271,462		20	13,573	13,573	61,726	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

Facility Name & ID Number Greenwood Care # 0031971 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	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		3,240,715	137,155		182,618	45,463	1,705,600	67
68	Related Party Allocations (Pages 12H & 12I)		98,202	2,965		3,975	1,010	43,778	68
69	Financial Statement Depreciation			49,737			(49,737)		69
70	TOTAL (lines 4 thru 69)		$ 4,785,100	$ 189,857		$ 259,857	$ 70,000	$ 2,526,298	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care # 0031971 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 12A, Carried Forward		$ 4,785,100	$ 189,857		$ 259,857	$ 70,000	$ 2,526,298	1
2	Fire Door	2007	2,925		20	293	293	1,146	2
3	Fire Door	2007	1,725		20	173	173	661	3
4	Sprinkler	2007	126,027		20	6,301	6,301	23,105	4
5	Boiler Work	2007	3,970		20	199	199	777	5
6	Fire Door	2007	1,175		20	118	118	421	6
7	Elevator Generator	2007	8,500		20	425	425	1,700	7
8	Fire Doors	2007	1,275		20	128	128	436	8
9	Elevator	2007	5,720		20	286	286	930	9
10	Bathroom Repairs	2007	2,560		20	128	128	427	10
11	Lighting	2008	4,653		20	233	233	659	11
12	Smoke Detectors	2008	3,732		20	187	187	529	12
13	Elevator Work	2008	8,954		20	448	448	933	13
14	Plumbing Repairs	2008	6,700		20	335	335	726	14
15	Elevator Repair	2008	5,000		20	250	250	667	15
16	Boiler Work	2009	4,839		20	242	242	484	16
17	Phone System	2009	10,392		20	520	520	996	17
18	Security Camera	2009	4,060		20	203	203	338	18
19	Mixing Valve	2009	5,711		20	286	286	357	19
20	Springler System Repair	2009	3,105		20	155	155	207	20
21	Replace Cylinders - Master Key System	2009	4,889		20	244	244	306	21
22	Boiler Work	2009	3,739		20	187	187	234	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)		$ 5,004,751	$ 189,857		$ 271,195	$ 81,338	$ 2,562,335	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care # 0031971 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 12B, Carried Forward		$ 5,004,751	$ 189,857		$ 271,195	$ 81,338	$ 2,562,335	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)		$ 5,004,751	$ 189,857		$ 271,195	$ 81,338	$ 2,562,335	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care # 0031971 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		$ 5,004,751	$ 189,857		$ 271,195	$ 81,338	$ 2,562,335	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)		$ 5,004,751	$ 189,857		$ 271,195	$ 81,338	$ 2,562,335	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care # 0031971 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 12D, Carried Forward		$ 5,004,751	$ 189,857		$ 271,195	$ 81,338	$ 2,562,335	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)		$ 5,004,751	$ 189,857		$ 271,195	$ 81,338	$ 2,562,335	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care # 0031971 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	Building Company Information								1
2	Buildings:								2
3	Greenwood Care Ltd.	1969	1,845,500	137,155		113,703	(23,452)	1,589,181	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Rear Freight Elevator	2008	141,600		20	7,080	7,080	21,240	9
10	Matthews Roofing - Masonry Work	2008	55,300		20	2,765	2,765	8,295	10
11	Flooring	2008	4,648		20	232	232	696	11
12	Nurses Stations - Cabinetry and Sinks	2008	29,158		20	1,458	1,458	4,374	12
13	Generator - Application/Permits, Engineering Cost	2009	16,844		30	561	561	1,122	13
14	Generator Cost and Installation	2009	189,600		30	6,320	6,320	12,640	14
15	Bathrooms - Valves, New Walls, Tiles, New Toilets, Sink	2009	42,000		20	2,100	2,100	4,200	15
16	Shower Room - Wall Work, Concrete, New Rubber Pan, Tiles	2009	4,375		20	219	219	438	16
17	Bathrooms - Valves, New Walls, Tiles, New Toilets, Sink	2009	52,500		20	2,625	2,625	5,250	17
18	Bathrooms - Valves, New Walls, Tiles, New Toilets, Sink	2009	94,500		20	4,725	4,725	9,450	18
19	Generator	2009	3,071		20	154	154	308	19
20	Bathrooms - Valves, New Walls, Tiles, New Toilets, Sink	2009	42,000		30	1,400	1,400	2,800	20
21	Bathrooms - Valves, New Walls, Tiles, New Toilets, Sink	2009	63,000		20	3,150	3,150	6,300	21
22	Bathrooms - Valves, New Walls, Tiles, New Toilets, Sink	2009	47,250		20	2,363	2,363	4,726	22
23	Roofing Work	2009	16,346		20	817	817	1,634	23
24									24
25	Boiler System	2010	72,862		20	3,643	3,643	3,643	25
26	Fl. 2 Shower Room - Wall Work, Concrete, Rubber Pan, Tiles	2010	6,700		10	670	670	670	26
27	First Floor -doors, wall work, replace ceiling tiles, carpet, tile	2010	140,819		20	7,041	7,041	7,041	27
28	Painting - First Floor	2010	27,225		20	1,361	1,361	1,361	28
29	Flooring - 2 and 3	2010	17,238		20	862	862	862	29
30	Lintel Work	2010	21,500		20	1,075	1,075	1,075	30
31	Resident Door Locks	2010	7,297		20	365	365	365	31
32	Electric - basement closet & lighting, utility room circuitry	2010	4,498		20	225	225	225	32
33	Kitchen Ceiling	2010	5,320		20	266	266	266	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 Greenwood Care # 0031971 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	Building Company Information Continued		$	$		$	$	$	1
2	FL 4 - Shower Room - Wall Work, Concrete, New Rubber Pan, Tiles	2010	18,200		20	910	910	910	2
3	Wallpaper - First Floor & Conference Room	2010	8,175		20	409	409	409	3
4	FL1 Front, 2 Hallway Bath - ceiling, doors, hardware,toilet, sink, fauce	2010	15,503		20	775	775	775	4
5	Window Openings - Remodeling, Plaster, Drywall	2010	7,200		20	360	360	360	5
6	First Floor Remodeling - Wallpaper, Tiles	2010	9,512		20	476	476	476	6
7	Oxygen Room -replace vinyl flooring, duct work, install light, fan	2010	13,250		10	1,325	1,325	1,325	7
8	Elevator Panels	2010	2,900		10	290	290	290	8
9	Rooftop Fence/Coping	2010	11,690		20	585	585	585	9
10	Window Replacement	2010	81,115		20	4,056	4,056	4,056	10
11	Elevator Motor	2010	5,600		20	280	280	280	11
12	Fire Doors	2010	3,260		10	326	326	326	12
13	Replace antenae system with cable TV	2010	17,257		20	863	863	863	13
14	Fire Door	2010	2,650		10	265	265	265	14
15	Window Treatments	2010	29,426		10	2,943	2,943	2,943	15
16	Window Treatments	2010	3,103		10	310	310	310	16
17	Handrails	2010	22,860		20	1,143	1,143	1,143	17
18	Window Treatments - Dining Room	2010	4,611		10	461	461	461	18
19	Rail and Guards - Dining Room	2010	3,984		20	199	199	199	19
20	Condenser Fan/Outlet	2010	2,579		20	129	129	129	20
21	Steampipe Work - Water Leaks	2010	2,580		20	129	129	129	21
22	Regrout Kitchen Floor	2010	2,862		20	143	143	143	22
23	Roof Repairs & Coating	2010	2,980		20	149	149	149	23
24	Wall Base Repairs	2010	6,267		20	313	313	313	24
25	Tuckpointing	2010	5,500		20	275	275	275	25
26	Parapet Repairs	2010	6,500		20	325	325	325	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$ 3,240,715	$ 137,155		$ 182,618	$ 45,463	$ 1,705,600	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care # 0031971 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	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	S.I.R. Properties - S.I.R. Management - Allocation	1993	27,239	865	35	778	(87)	13,619	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	S.I.R. Management Inc.	1993	6,906	192	20	342	150	6,163	9
10	S.I.R. Management Inc.	1994	22		10			22	10
11	S.I.R. Management Inc.	1995	158		20	8	8	122	11
12	S.I.R. Management Inc.	1997	10,612	238	20	531	293	7,327	12
13	S.I.R. Management Inc.	1999	834		20	42	42	469	13
14	S.I.R. Management Inc.	1999	8,112		20			8,112	14
15	S.I.R. Management Inc.	2000	985		20	49	49	519	15
16	S.I.R. Management Inc.	2007	3,165	339	20	158	(181)	506	16
17	S.I.R. Management Inc.	2008	8,723	872	20	550	(322)	1,564	17
18	S.I.R. Management Inc.	2009	21,676	198	20	1,084	886	1,349	18
19									19
20	S.I.R. Properties - S.I.R. Management - Allocation	2010	1,644		20	27	27	27	20
21	S.I.R. Properties - S.I.R. Management - Allocation	2009	1,636	200	20	82	(118)	147	21
22	S.I.R. Properties - S.I.R. Management - Allocation	2007	477	52	20	24	(28)	95	22
23	S.I.R. Properties - S.I.R. Management - Allocation	2002	108		20	5	5	46	23
24	S.I.R. Properties - S.I.R. Management - Allocation	1999	3,452		20	173	173	1,985	24
25	S.I.R. Properties - S.I.R. Management - Allocation	1998	1,649		20	82	82	1,031	25
26	S.I.R. Properties - S.I.R. Management - Allocation	1997	103		20	5	5	74	26
27	S.I.R. Properties - S.I.R. Management - Allocation	1994	259	7	20	13	6	214	27
28	S.I.R. Properties - S.I.R. Management - Allocation	1993	442	2	20	22	20	387	28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care # 0031971 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	Related Party Information Continued								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)		$ 98,202	$ 2,965		$ 3,975	$ 1,010	$ 43,778	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care # 0031971 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	$ 521,943	$ 3,277	$ 23,354	$ 20,077	10	$ 364,838	71
72	Current Year Purchases	37,624	98	3,731	3,633	10	4,291	72
73	Fully Depreciated Assets	169,730		48	48	10	169,729	73
74								74
75	TOTALS	$ 729,297	$ 3,375	$ 27,133	$ 23,758		$ 538,858	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	Facility	PASSENGER VAN	2007	$ 14,137	$	$ 2,355	$ 2,355	5	$ 10,604	76
77	Facility	Allocated from SIR Management	1988	1,595	120	120		5	120	77
78										78
79										79
80	TOTALS			$ 15,732	$ 120	$ 2,475	$ 2,355		$ 10,724	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,902,335	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 193,352	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 300,803	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 107,451	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,111,917	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.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] 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: ____ *

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	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 13,151 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	N/A	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental									13
14	TOTAL			$		$	$		$	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

STATE OF ILLINOIS

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/10 Ending: 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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 10,655	$ 34,332	1
2	Cash-Patient Deposits	34,999	34,999	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	639,383	639,383	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,525	30,122	6
7	Other Prepaid Expenses	2,450	2,450	7
8	Accounts Receivable (owners or related parties)	45,326	45,326	8
9	Other(specify): See Attached Schedule	115,160	568,565	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 877,498	$ 1,355,177	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		152,555	13
14	Buildings, at Historical Cost		2,274,062	14
15	Leasehold Improvements, at Historical Cost	993,251	2,157,634	15
16	Equipment, at Historical Cost	953,433	1,398,959	16
17	Accumulated Depreciation (book methods)	(1,158,545)	(2,868,133)	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): See Attached Schedule	113,625	250,329	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 901,764	$ 3,365,406	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,779,262	$ 4,720,583	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 192,388	$ 283,312	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	35,545	35,545	28
29	Short-Term Notes Payable	525,000	525,000	29
30	Accrued Salaries Payable	187,098	187,098	30
31	Accrued Taxes Payable (excluding real estate taxes)	25,026	25,026	31
32	Accrued Real Estate Taxes(Sch.IX-B)		132,000	32
33	Accrued Interest Payable		46,558	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule		140,364	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 965,057	$ 1,374,903	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,139,520	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 12,139,520	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 965,057	$ 13,514,423	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 814,205	$ (8,793,840)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,779,262	$ 4,720,583	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,006,822	1
2	Restatements (describe):		2
3	**Rounding Adjustment**	3	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,006,825	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(76,620)	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	(116,000)	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)**	$ (192,620)	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)**	$ 814,205	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/10 Ending: 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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,416,043	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,416,043	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,200	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,200	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,417,243	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,094,813	31
32	Health Care	1,714,086	32
33	General Administration	1,543,635	33
	B. Capital Expense		
34	Ownership	1,061,608	34
	C. Ancillary Expense		
35	Special Cost Centers	333	35
36	Provider Participation Fee	79,388	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,493,863	40
41	**Income before Income Taxes (line 30 minus line 40)****	(76,620)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (76,620)	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 Greenwood Care # 0031971 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 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,151	2,285	$ 72,675	$ 31.81	1
2	Assistant Director of Nursing	1,869	2,086	55,097	26.41	2
3	Registered Nurses	250	809	24,752	30.60	3
4	Licensed Practical Nurses	13,325	13,834	356,526	25.77	4
5	CNAs & Orderlies	46,879	52,696	605,037	11.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,010	2,086	29,896	14.33	9
10	Activity Assistants	13,758	14,733	141,721	9.62	10
11	Social Service Workers	14,464	15,780	223,560	14.17	11
12	Dietician	2,029	2,086	34,147	16.37	12
13	Food Service Supervisor					13
14	Head Cook	6,856	7,256	65,885	9.08	14
15	Cook Helpers/Assistants	8,289	8,702	82,397	9.47	15
16	Dishwashers					16
17	Maintenance Workers	3,418	3,815	45,359	11.89	17
18	Housekeepers	18,352	19,776	198,077	10.02	18
19	Laundry					19
20	Administrator	1,949	2,086	82,223	39.42	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,561	17,752	171,433	9.66	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,096	2,245	24,978	11.13	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	154,256	168,027	$ 2,213,763 *	$ 13.18	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	161	$ 9,056	01-03	35
36	Medical Director	Monthly	7,800	09-03	36
37	Medical Records Consultant	Monthly	4,416	10-03	37
38	Nurse Consultant	Monthly	31,320	10-03	38
39	Pharmacist Consultant	Monthly	8,916	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	4,355	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Specialized Rehab Consultant	Monthly	15,660	10A-03	47
48	Director of Food Services	Monthly	15,660	01-03	48
49	TOTAL (lines 35 - 48)	161	$ 97,183		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	7	$ 406	10-03	50
51	Licensed Practical Nurses	1,595	55,979	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,602	$ 56,385		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Delvin Rychener	Administrator		$ 82,223
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 82,223

B. Administrative - Other

Description	Amount
SIR Management - Consulting Fees	$ 375,954
SIR Management - Director of Administrative Services	31,320
SIR Management - Owners Council Dues	7,836
See Supplemetal Schedule	32,196
TOTAL (agree to Schedule V, line 17, col. 3)	$ 447,306
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SIR Management	Accounting	$ 36,000
SIR Management	Bookkeeping Services	60,888
SIR Management	Dir of Regulatory Services	15,660
Pinnacle Consulting	Customer Satisfaction Program	2,287
LTC Solutions	MDS Software	1,800
Property Valuation Services	Appraising	2,500
Frost, Ruttenburg, & Rothblatt	Accounting	16,005
Personnel Planners	Unemployment Tax Consult.	1,505
See Attached	Legal	13,239
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 149,884

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 40,325
Unemployment Compensation Insurance	19,560
FICA Taxes	167,318
Employee Health Insurance	81,351
Employee Meals	18,907
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension Plan	21,503
Union Health & Welfare	63,174
401K Matching Contributions	4,250
Employee Benefits - Other	4,990
TOTAL (agree to Schedule V, line 22, col.8)	$ 421,378

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 996
Advertising: Employee Recruitment	439
Health Care Worker Background Check	1,740
(Indicate # of checks performed 49)	
Patient Background Checks	
Licenses & Permits	10,329
Dues & Subscriptions	8,545
SIR Management Allocation	170
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,219

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,783
Allocated from SIR Management	720
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,503

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Greenwood Care # 0031971 **Report Period Beginning:** 01/01/10 **Ending:** 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. **See Attached**

(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. $ **14,844** 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. $ **79,388**
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? **N/A**

(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. $ **18,907** Has any meal income been offset against related costs? **No** 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? **None**
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? **N/A**

(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.