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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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: 1/1/1990

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 01/01/14 to 12/31/14 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**

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	32,617	1,143	12,710	46,470	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,617	1,143	12,710	46,470	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.80%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
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 2/1/1987

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/1/1987 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 N/A

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: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	183,856	19,664	26,546	230,066		230,066	(12,845)	217,221			1
2	Food Purchase		245,798		245,798	(20,568)	225,230	(1,260)	223,970			2
3	Housekeeping	205,271	27,277		232,548		232,548		232,548			3
4	Laundry		8,798	12,040	20,838		20,838		20,838			4
5	Heat and Other Utilities			121,183	121,183		121,183	(10,692)	110,491			5
6	Maintenance	52,679	38,364	126,283	217,326		217,326	5,550	222,876			6
7	Other (specify):*							6,226	6,226			7
8	TOTAL General Services	441,806	339,901	286,052	1,067,759	(20,568)	1,047,191	(13,021)	1,034,170			8
	B. Health Care and Programs											
9	Medical Director			7,750	7,750		7,750		7,750			9
10	Nursing and Medical Records	1,056,478	29,795	50,312	1,136,585		1,136,585	(8,879)	1,127,706			10
10a	Therapy	26,872		17,400	44,272		44,272	(8,938)	35,334			10a
11	Activities	162,416	9,996	2,501	174,913		174,913		174,913			11
12	Social Services	206,759			206,759		206,759		206,759			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							4,938	4,938			15
16	TOTAL Health Care and Programs	1,452,525	39,791	77,963	1,570,279		1,570,279	(12,879)	1,557,400			16
	C. General Administration											
17	Administrative	79,576		332,138	411,714		411,714	(247,430)	164,284			17
18	Directors Fees											18
19	Professional Services			151,414	151,414	(14,576)	136,838	(84,638)	52,200			19
20	Dues, Fees, Subscriptions & Promotions			55,420	55,420		55,420	(24,714)	30,706			20
21	Clerical & General Office Expenses	195,668	20,601	83,474	299,743		299,743	66,661	366,404			21
22	Employee Benefits & Payroll Taxes			375,759	375,759	20,568	396,327		396,327			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,249	4,249		4,249	641	4,890			24
25	Other Admin. Staff Transportation			4,754	4,754		4,754	7,945	12,699			25
26	Insurance-Prop.Liab.Malpractice			105,898	105,898		105,898	10,520	116,418			26
27	Other (specify):*							32,731	32,731			27
28	TOTAL General Administration	275,244	20,601	1,113,106	1,408,951	5,992	1,414,943	(238,284)	1,176,659			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,169,575	400,293	1,477,121	4,046,989	(14,576)	4,032,413	(264,184)	3,768,229			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
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:** 01/01/14 **Ending:** 12/31/14

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			40,343	40,343		40,343	153,371	193,714			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							388,989	388,989			32
33	Real Estate Taxes					14,576	14,576	206,412	220,988			33
34	Rent-Facility & Grounds			1,016,000	1,016,000		1,016,000	(1,016,000)				34
35	Rent-Equipment & Vehicles			6,297	6,297		6,297	5,066	11,363			35
36	Other (specify):*							64,841	64,841			36
37	**TOTAL Ownership**			1,062,640	1,062,640	14,576	1,077,216	(197,321)	879,895			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):*											43
44	**TOTAL Special Cost Centers**											44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,169,575	400,293	2,539,761	5,109,629		5,109,629	(461,505)	4,648,124			45

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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	(12,248)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(15,605)	30		9
10	Interest and Other Investment Income	(4,314)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(60)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(14,827)	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	(7,395)	21		24
25	Fund Raising, Advertising and Promotional	(4,481)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,146)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(32,266)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (94,342)		$	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)	(367,163)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (367,163)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (461,505)		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

Greenwood Care

ID# 0031971

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Fees	$ (7,072)	21	1
2	Theft & Damage	(50)	21	2
3	Vending Income	(1,200)	02	3
4	Jury Duty Income	(17)	10	4
5	Bldg Co. - Filing Fees	(350)	21	5
6	Bldg Co. - Office Expense	(12)	21	6
7	Bldg Co. - Professional Fees	(6,354)	19	7
8	Bldg Co. - Capitalized R&M	(9,118)	06	8
9	Non Allowable Legal Fees	(403)	19	9
10	PAC Dues	(7,690)	20	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
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**	(32,266)		49

Greenwood Care

ID# 0031971

Report Period Beginning: 01/01/14

Ending: 12/31/14

	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	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Greenwood Care # 0031971 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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				(12,845)								(12,845)	1
2	Food Purchase	(1,260)											(1,260)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(12,248)			1,556								(10,692)	5
6	Maintenance	(9,118)	12,460	(8,710)	10,918								5,550	6
7	Other (specify):*			545	5,681								6,226	7
8	**TOTAL General Services**	(22,626)	12,460	(8,165)	5,310								(13,021)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(17)		(15,165)	6,303								(8,879)	10
10a	Therapy				(8,938)								(8,938)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			2,776	2,162								4,938	15
16	**TOTAL Health Care and Programs**	(17)		(12,389)	(473)								(12,879)	16
	C. General Administration													
17	Administrative			(311,189)	63,759								(247,430)	17
18	Directors Fees													18
19	Professional Services	(6,757)	6,354	(97,017)	12,782								(84,638)	19
20	Fees, Subscriptions & Promotions	(26,998)		2,284									(24,714)	20
21	Clerical & General Office Expenses	(18,025)	362	84,268	56								66,661	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			641									641	24
25	Other Admin. Staff Transportation			7,945									7,945	25
26	Insurance-Prop.Liab.Malpractice		8,751	1,658	111								10,520	26
27	Other (specify):*			19,566	13,165								32,731	27
28	**TOTAL General Administration**	(51,780)	15,467	(291,844)	89,873								(238,284)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(74,423)	27,927	(312,398)	94,710								(264,184)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Greenwood Care **#** 0031971 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(15,605)	164,445		4,531								153,371	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(4,314)	404,175	(15,800)	4,928								388,989	32
33	Real Estate Taxes		200,472		5,940								206,412	33
34	Rent-Facility & Grounds		(1,016,000)										(1,016,000)	34
35	Rent-Equipment & Vehicles			5,066									5,066	35
36	Other (specify):*		64,841										64,841	36
37	TOTAL Ownership	(19,919)	(182,067)	(10,734)	15,399								(197,321)	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):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(94,342)	(154,140)	(323,132)	110,109								(461,505)	45

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 6- Supplemental		See 6- Supplemental		See 6- Supplemental		

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	$ 1,016,000	Greenwood Care LLC	100.00%	$	$ (1,016,000)	1
2	V	32	Interest	93	Greenwood Care LLC	100.00%	404,268	404,175	2
3	V	06	R & M		Greenwood Care LLC	100.00%	12,460	12,460	3
4	V	21	Filing Fees		Greenwood Care LLC	100.00%	350	350	4
5	V	36	Mortgage Insurance		Greenwood Care LLC	100.00%	64,841	64,841	5
6	V	21	Office Expense		Greenwood Care LLC	100.00%	12	12	6
7	V	26	Property Insurance		Greenwood Care LLC	100.00%	8,751	8,751	7
8	V	33	Real Estate Taxes		Greenwood Care LLC	100.00%	200,472	200,472	8
9	V	30	Depreciation		Greenwood Care LLC	100.00%	164,445	164,445	9
10	V	19	Professional Fees		Greenwood Care LLC	100.00%	6,354	6,354	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,016,093			$ 861,953	$ * (154,140)	14

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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.	$ 17,400	S.I.R. MANAGEMENT, INC.	100.00%	$ 8,690	$ (8,710)	15
16	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	545	545	16
17	V	10	NURSING	34,800	S.I.R. MANAGEMENT, INC.	100.00%	19,635	(15,165)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	2,776	2,776	18
19	V	19	PROFESSIONAL FEES	110,820	S.I.R. MANAGEMENT, INC.	100.00%	8,231	(102,589)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	2,284	2,284	20
21	V	21	CLERICAL & GENERAL	34,800	S.I.R. MANAGEMENT, INC.	100.00%	36,572	1,772	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	641	641	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	7,945	7,945	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,658	1,658	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	5,768	5,768	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(15,800)	(15,800)	26
27	V	35	AUTO RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	4,214	4,214	27
28	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	852	852	28
29	V								29
30	V	17	ADMINISTRATIVE	332,138	S.I.R. MANAGEMENT, INC.	100.00%	20,949	(311,189)	30
31	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	5,572	5,572	31
32	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	82,496	82,496	32
33	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	13,798	13,798	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 529,958			$ 206,826	$ * (323,132)	39

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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 17,400	S.I.R. MANAGEMENT, INC.	100.00%	$ 4,555	$ (12,845)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	672	672	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	6,303	6,303	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	898	898	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	63,759	63,759	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	12,178	12,178	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	13,165	13,165	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	17,400	S.I.R. MANAGEMENT, INC.	100.00%	8,462	(8,938)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,264	1,264	25
26	V								26
27	V	6	MAINTENANCE SALARIES	22,333	S.I.R. MANAGEMENT, INC.	100.00%	32,029	9,696	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	5,009	5,009	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	1,556	1,556	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	1,222	1,222	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	604	604	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	56	56	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	111	111	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	4,531	4,531	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	4,928	4,928	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	5,940	5,940	37
38	V								38
39	Total			$ 57,133			$ 167,242	$ * 110,109	39

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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: 01/01/14 Ending: 12/31/14

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: 01/01/14 Ending: 12/31/14

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: 01/01/14 Ending: 12/31/14

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: 01/01/14 Ending: 12/31/14

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: 01/01/14 Ending: 12/31/14

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: 01/01/14 Ending: 12/31/14

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: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ERIC ROTHNER	51.724%	APPLEWOOD REHABILITATION CENTER LLC	MATTESON	ALBANY CARE LLC	LINCOLNWOOD	BUILDING CO.	1
2	DENNIS TOSSI	2.759%	BRYN MAWR CARE INC	CHICAGO	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO	2
3	LOUISE BERGTHOLD	3.448%	COLUMBUS PARK NURSING & REHABILITATION CENTER INC	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	THOMAS WINTER	4.138%	DECATUR MANOR HEALTHCARE LLC	DECATUR	OAKTON ARMS	DES PLAINES	ASSISTED LIVING	4
5	MICHAEL R. GIANNINI TRUST DTD 3/13/00	3.448%	ELMWOOD CARE INC	ELMWOOD PARK				5
6	CELESTE GIANNINI TRUST DTD 3/13/00	3.448%	ALBANY CARE INC	EVANSTON				6
7	JULIANA R BARRISH TRUST DTD 1/26/93	15.517%	NEIGHBORS REHABILTATION CENTER LLC	BYRON				7
8	BRYAN BARRISH TRUST DTD 9/01/04	15.517%	REGENCY REHABILITATION CENTER LLC	NILES				8
9			ROCK ISLAND NURSING & REHAB CENTER LLC	ROCK ISLAND				9
10			WILSON CARE INC	CHICAGO				10
11			WESLEY REHABILITATION CENTER	AUBURN, IN				11
12			OAKTON PAVILION	DES PLAINES				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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Bryan Barrish	Relative	Administrative		See Attached	2.47	5.49%	Alloc. Salary	$ 12,367	17-7	1
2	Kirsten Barrish	Relative	Clerical		See Attached	3.09	6.18%	Alloc. Salary	5,704	21-7	2
3	Sarah Barrish	Relative	Administrative		See Attached	2.78	6.18%	Alloc. Salary	7,523	17-7	3
4	Louise Bergthold	Owner	Administrative	3.45%	See Attached	3.71	6.18%	Alloc. Salary	12,367	17-7	4
5	Michael Giannini	Relative	Administrative		See Attached	2.16	5.40%	Alloc. Salary	10,322	17-7	5
6	Nenita Guzman	Relative	Dietary		See Attached	3.09	6.18%	Alloc. Salary	4,555	1-7	6
7	Tom Winter	Owner	Administrative	4.14%	See Attached	3.71	6.18%	Alloc. Salary	12,367	17-7	7
8	Thomas Bergthold	Relative	Clerical		See Attached	2.47	6.18%	Alloc. Salary	2,497	21-7	8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 67,702		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: 01/01/14 Ending: 12/31/14

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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	751,530	16	$ 140,542	$ 58,090	46,470	$ 8,690	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	751,530	16	8,819		46,470	545	2
3	10	NURSING	PATIENT DAYS	751,530	16	317,539	317,539	46,470	19,635	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	751,530	16	44,898		46,470	2,776	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	751,530	16	133,120	89,849	46,470	8,231	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	751,530	16	36,940		46,470	2,284	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	751,530	16	591,459	531,411	46,470	36,572	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	751,530	16	10,362		46,470	641	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	751,530	16	128,491		46,470	7,945	9
10	26	INSURANCE	PATIENT DAYS	751,530	16	26,818		46,470	1,658	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	751,530	16	93,282		46,470	5,768	11
12	32	INTEREST	PATIENT DAYS	751,530	16	(255,531)		46,470	(15,800)	12
13	35	AUTO RENTAL	PATIENT DAYS	751,530	16	68,150		46,470	4,214	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	751,530	16	13,772		46,470	852	14
15										15
16	17	ADMINISTRATIVE	PATIENT DAYS	751,530	16	338,802	338,802	46,470	20,949	16
17	19	PROFESSIONAL FEES	PATIENT DAYS	751,530	16	90,119		46,470	5,572	17
18	21	CLERICAL & GENERAL	PATIENT DAYS	751,530	16	1,334,152	1,203,304	46,470	82,496	18
19	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	751,530	16	223,152		46,470	13,798	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,344,886	$ 2,538,995		$ 206,826	25

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	751,530	16	$ 73,669	$ 73,669	46,470	$ 4,555	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	751,530	16	10,866		46,470	672	2
3	10	NURSING SALARIES	PATIENT DAYS	751,530	16	101,941	101,941	46,470	6,303	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	751,530	16	14,528		46,470	898	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	751,530	16	1,031,137	1,031,137	46,470	63,759	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	751,530	16	196,950		46,470	12,178	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	751,530	16	212,914		46,470	13,165	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	274,680	15	133,582	133,582	17,400	8,462	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	274,680	15	19,951		17,400	1,264	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	395,144	15	566,698	566,698	22,333	32,029	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	395,144	15	88,633		22,333	5,009	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,880	15	25,179		796	1,556	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,880	15	19,781		796	1,222	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,880	15	9,777		796	604	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,880	15	907		796	56	19
20	26	INSURANCE	ALLOCATED SQ FT	12,880	15	1,804		796	111	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,880	15	73,312		796	4,531	21
22	32	INTEREST	ALLOCATED SQ FT	12,880	15	79,739		796	4,928	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,880	15	96,114		796	5,940	23
24										24
25	TOTALS					$ 2,757,482	$ 1,907,027		$ 167,242	25

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: 01/01/14 Ending: 12/31/14

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: 01/01/14 Ending: 12/31/14

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: 01/01/14 Ending: 12/31/14

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: 01/01/14 Ending: 12/31/14

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: 01/01/14 Ending: 12/31/14

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: 01/01/14 Ending: 12/31/14

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: 01/01/14 Ending: 12/31/14

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	Mortgage			$	$ 11,452,629			$ 404,268	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Lake Forest Bank		X	Line of Credit				175,000				6
7	Allocated from SIR Managemer	X									4,928	7
8												8
9	TOTAL Facility Related						$	$ 11,627,629			$ 409,196	9
	B. Non-Facility Related*											
10	Interest Income		X								(93)	10
11	Interest Income - Bldg Co		X								(4,314)	11
12	Allocated from SIR Managemer	X									(15,800)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (20,207)	14
15	TOTALS (line 9+line14)						$	$ 11,627,629			$ 388,989	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ 64,841 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.)**

**** 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: 01/01/14 Ending: 12/31/14

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:** 01/01/14 **Ending:** 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 197,500	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.)		$ 199,912	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,412	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 204,000	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.)**		$ 14,576	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** $ 39,080 **For** 2010 **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.		$ 220,988	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	125,620	8
	2010	178,650	9
	2011	179,522	10
	2012	188,087	11
	2013	193,972	12

2014 Accrual = $193,972 x 1.05 = $204,000 (Rounded)

Allocated from SIR Management = $5,940

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 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 2013 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 2013.

	(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	$ 193,972.22	$ 193,972.22
2.	See Attached	See Attached	$ 116,016.54	$ 5,615.20
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 309,988.76	$ 199,587.42

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 and 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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		1987	$ 152,555	1
2					2
3	TOTALS			$ 152,555	3

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	145		1987	1969	$ 1,845,500	$ 72,192	35	$	$ (72,192)	$ 1,845,500	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1984	2,672		20	76	76	2,183	9
10	Various			1987	24,869		20	694	694	20,510	10
11	Various			1988	27,733		20	321	321	20,319	11
12	Various			1989	7,668		20	87	87	5,766	12
13	Various			1990	9,800		20			9,235	13
14	Various			1992	25,025		20			25,019	14
15	Various			1993	63,911		20			63,906	15
16	Various			1994	20,319		20	616	616	20,315	16
17	Various			1995	73,839		20	3,692	3,692	72,335	17
18	Various			1996	109,220		20	5,461	5,461	101,309	18
19	Various			1997	73,171		20	3,659	3,659	64,046	19
20	Various			1998	58,371		20	2,919	2,919	48,094	20
21	Various			1999	179,834		20	9,098	9,098	141,127	21
22	Various			2000	171,876		20	8,594	8,594	126,403	22
23	Various			2001	43,730		20	2,187	2,187	30,277	23
24	Various			2002	87,606		20	3,432	3,432	61,309	24
25	Various			2003	59,109		20	1,707	1,707	44,109	25
26	Various			2004	77,107		20	3,637	3,637	47,691	26
27	Various			2005	58,861		20	3,273	3,273	30,876	27
28	Various			2006	271,462		20	13,573	13,573	116,018	28
29	Various			2007	153,877		20	8,049	8,049	61,798	29
30	Various			2008	29,039		20	1,452	1,452	9,321	30
31	Various			2009	36,735		20	1,837	1,837	10,268	31
32	Various			2010	11,568		20	1,157	1,157	4,724	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: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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)		1,544,040	63,495		76,670	13,175	425,511	67
68	Related Party Allocations (Pages 12H & 12I)		120,359	3,031		4,299	1,268	62,990	68
69	Financial Statement Depreciation			40,343			(40,343)		69
70	TOTAL (lines 4 thru 69)		$ 5,187,301	$ 179,061		$ 156,487	$ (22,574)	$ 3,470,960	70

**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: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 5,187,301	$ 179,061		$ 156,487	$ (22,574)	$ 3,470,960	1
2	Fire Rated Doors	2011	3,400		20	170	170	680	2
3	Windows: Rear Stairwell	2011	2,603		20	130	130	423	3
4	Sink Moved 2 Feet	2011	2,754		20	275	275	1,079	4
5	Test And Repair Fire Alarms	2011	2,507		20	251	251	1,003	5
6	Electric Wiring	2012	22,000		20	1,100	1,100	3,300	6
7	Elevator Recall System	2012	14,490		20	725	725	1,932	7
8	Remodel 5Th Floor Shower Room	2012	10,400		20	520	520	1,387	8
9	Stairwell Railing	2012	6,580		20	658	658	1,371	9
10	Sprinkler System Repair	2012	2,706		20	135	135	304	10
11	Sprinkler System Work	2013	6,322		20	316	316	474	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)		$ 5,261,063	$ 179,061		$ 160,767	$ (18,294)	$ 3,482,912	34

**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: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 5,261,063	$ 179,061		$ 160,767	$ (18,294)	$ 3,482,912	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)		$ 5,261,063	$ 179,061		$ 160,767	$ (18,294)	$ 3,482,912	34

**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: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 5,261,063	$ 179,061		$ 160,767	$ (18,294)	$ 3,482,912	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)		$ 5,261,063	$ 179,061		$ 160,767	$ (18,294)	$ 3,482,912	34

**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: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 5,261,063	$ 179,061		$ 160,767	$ (18,294)	$ 3,482,912	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)		$ 5,261,063	$ 179,061		$ 160,767	$ (18,294)	$ 3,482,912	34

**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: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9	Various	2008	230,706		20	11,535	11,535	80,745	9
10	Various	2009	571,486		20	24,434	24,434	146,513	10
11	Boiler System	2010	72,862		20	3,643	3,643	18,215	11
12	FL 2 Shower Room- Wall Work, Concrete, Rubber Pan, Tiles	2010	6,700		20	670	670	3,350	12
13	First Floor- Doors, wall work, replace ceiling tiles, carpet, tile	2010	140,819		20	7,041	7,041	35,205	13
14	Painting- First Floor	2010	27,225		20	1,361	1,361	6,805	14
15	Flooring 2-3	2010	17,238		20	862	862	4,310	15
16	Lintel Work	2010	21,500		20	1,075	1,075	5,375	16
17	Resident Door Locks	2010	7,297		20	365	365	1,825	17
18	Electric- basement closet & lighting, utility room	2010	4,498		20	225	225	1,125	18
19	Kitchen Ceiling	2010	5,320		20	266	266	1,330	19
20	FL 4 Shower Room- Wall Work, Concrete, Rubber Pan, Tiles	2010	18,200		20	910	910	4,550	20
21	Wallpaper- First Floor & Conference Room	2010	8,175		20	409	409	2,045	21
22	FL1 Front, 2 Hallway Bath- ceiling, doors, hardware, toilet	2010	15,503		20	775	775	3,875	22
23	Window Openings- Remodeling, Plaster, Drywall	2010	7,200		20	360	360	1,800	23
24	First Floor Remodeling- Wallpaper, Tiles	2010	9,512		20	476	476	2,380	24
25	Oxygen Room- Replace vinyle flooring, duct work	2010	13,250		20	1,325	1,325	6,625	25
26	Elevator Panels	2010	2,900		20	290	290	1,450	26
27	Rooftop Fence/Coping	2010	11,690		20	585	585	2,925	27
28	Window Replacement	2010	81,115		20	4,056	4,056	20,280	28
29	Elevator Motor	2010	5,600		20	280	280	1,400	29
30	Fire Doors	2010	3,260		20	326	326	1,630	30
31	Replace antenae system with cable TV	2010	11,007		20	863	863	4,315	31
32	Fire Doors	2010	2,650		20	265	265	1,325	32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,295,713	$		$ 62,397	$ 62,397	$ 359,398	34

**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: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 1,295,713	$		$ 62,397	$ 62,397	$ 359,398	1
2	Window Treatments	2010	29,426		20	2,943	2,943	14,715	2
3	Window Treatments	2010	3,103		20	310	310	1,550	3
4	Handrails	2010	22,860		20	1,143	1,143	5,715	4
5	Window Treatments- Dining Room	2010	4,611		20	461	461	2,305	5
6	Rail and Guards- Dining Rooms	2010	3,984		20	199	199	995	6
7	Condenser Fan/Outlet	2010	2,579		20	129	129	645	7
8	Steampipe Work- Water Leaks	2010	2,580		20	129	129	645	8
9	Regrout Kitchen Floor	2010	2,862		20	143	143	715	9
10	Roof Repairs & Coating	2010	2,980		20	149	149	745	10
11	Wall Base Repairs	2010	6,267		20	313	313	1,565	11
12	Tuckpointing	2010	5,500		20	275	275	1,375	12
13	Parapet Repairs	2010	6,500		20	325	325	1,625	13
14	Grease Interceptor & Floor Drain	2011	7,400		20	370	370	1,480	14
15	Coffee Shop Custom Cabinet	2011	3,000		20	150	150	600	15
16	Painting of Entire Facility	2010	107,900		20	5,395	5,395	26,975	16
17	Duct extensions- community bathrooms	2012	5,321		20	266	266	798	17
18	Sprinkler System Repair	2012	3,367		20	168	168	504	18
19	Boiler Repair	2012	3,326		20	166	166	498	19
20	Kitchen-patch walls and paint	2012	3,700		20	185	185	555	20
21	Elevator Generator	2013	5,500		20	275	275	550	21
22	Nurse Call Annuciator	2013	8,331		20	417	417	834	22
23	Camera Security System	2013	7,230		20	362	362	724	23
24									24
25	Building Company Depreciation			63,495			(63,495)		25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,544,040	$ 63,495		$ 76,670	$ 13,175	$ 425,511	34

**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: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3	SIR Properties - SIR Management	1993	27,975	888	35	799	(89)	17,184	3
4	SIR Management	2009	15,450		39	396	396	1,997	4
5									5
6									6
7									7
8	Leasehold Information								8
9	Alloc. - S.I.R. Management	1993	7,093	197	20		(197)	7,093	9
10	Alloc. - S.I.R. Management	1994	22		20			22	10
11	Alloc. - S.I.R. Management	1995	162		20	8	8	157	11
12	Alloc. - S.I.R. Management	1997	10,898	244	20	531	287	9,653	12
13	Alloc. - S.I.R. Management	1999	857		20	43	43	653	13
14	Alloc. - S.I.R. Management	1999	8,112		20			8,112	14
15	Alloc. - S.I.R. Management	2000	1,012		20	51	51	736	15
16	Alloc. - S.I.R. Management	2007	3,251	222	20	163	(59)	1,169	16
17	Alloc. - S.I.R. Management	2008	8,959	856	20	565	(291)	3,865	17
18	Alloc. - S.I.R. Management	2009	22,261	204	20	1,113	909	5,837	18
19	Alloc. - S.I.R. Management	2011	551	55	20	55		188	19
20	Alloc. - S.I.R. Management	2012	1,762	88	20	88		213	20
21	Alloc. - S.I.R. Management	2014	247		20	7	7	7	21
22									22
23	Alloc. - S.I.R. Properties - S.I.R. Management	2012	1,714	169	20	8	(161)	22	23
24	Alloc. - S.I.R. Properties - S.I.R. Management	2010	1,688		20	84	84	366	24
25	Alloc. - S.I.R. Properties - S.I.R. Management	2009	1,680	75	20	84	9	487	25
26	Alloc. - S.I.R. Properties - S.I.R. Management	2007	490	24	20	24		196	26
27	Alloc. - S.I.R. Properties - S.I.R. Management	2002	111		20	6	6	70	27
28	Alloc. - S.I.R. Properties - S.I.R. Management	1999	3,545		20	177	177	2,747	28
29	Alloc. - S.I.R. Properties - S.I.R. Management	1998	1,694		20	85	85	1,398	29
30	Alloc. - S.I.R. Properties - S.I.R. Management	1997	105		20	5	5	98	30
31	Alloc. - S.I.R. Properties - S.I.R. Management	1994	266	7	20	7		266	31
32	Alloc. - S.I.R. Properties - S.I.R. Management	1993	454	2	20		(2)	454	32
33									33
34	TOTAL (lines 1 thru 33)		$ 120,359	$ 3,031		$ 4,299	$ 1,268	$ 62,990	34

**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: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 120,359	$ 3,031		$ 4,299	$ 1,268	$ 62,990	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
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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)		$ 120,359	$ 3,031		$ 4,299	$ 1,268	$ 62,990	34

**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: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 586,007	$ 29,947	$ 31,310	$ 1,363	10	$ 432,115	71
72	Current Year Purchases	21,256	114	1,405	1,291	10	1,405	72
73	Fully Depreciated Assets	213,065				10	213,065	73
74								74
75	TOTALS	$ 820,328	$ 30,061	$ 32,715	$ 2,654		$ 646,585	75

D. Vehicle Costs. (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		PASSENGER VAN	2007	$ 14,137	$	$	$	5	$ 14,137	76
77		Allocated from SIR Management	2014	2,172	197	232	35	5	1,252	77
78										78
79										79
80	TOTALS			$ 16,309	$ 197	$ 232	$ 35		$ 15,389	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)	$	6,250,255	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	209,319	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	193,714	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	(15,605)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	4,144,886	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: 01/01/14 Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 7,149 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	Allocated from SIR Management		$	$ 4,214	17
18					18
19					19
20					20
21	TOTAL		$	$ 4,214	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.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

STATE OF ILLINOIS

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (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	$ 82,173	$ 137,185	1
2	Cash-Patient Deposits	43,092	43,092	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	468,474	468,474	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	26,978	43,494	6
7	Other Prepaid Expenses	2,933	2,933	7
8	Accounts Receivable (owners or related parties)	200,000	200,000	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 823,650	$ 895,178	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	1,070,814	2,374,558	15
16	Equipment, at Historical Cost	1,000,550	1,468,699	16
17	Accumulated Depreciation (book methods)	(1,326,830)	(3,689,088)	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):		311,455	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 744,534	$ 2,892,241	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,568,184	$ 3,787,419	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 118,539	$ 118,539	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	43,092	43,092	28
29	Short-Term Notes Payable	175,000	175,000	29
30	Accrued Salaries Payable	188,223	188,223	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,411	16,411	31
32	Accrued Real Estate Taxes(Sch.IX-B)		204,000	32
33	Accrued Interest Payable		33,404	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	7,217	7,217	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 548,482	$ 785,886	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,452,629	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43			766,297	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 12,218,926	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 548,482	$ 13,004,812	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,019,702	$ (9,217,393)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,568,184	$ 3,787,419	48

*(See instructions.)

Facility Name & ID Number Greenwood Care **#** 0031971 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 977,703	1	
2	Restatements (describe):		2	
3	**Rounding**	(1)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 977,702	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	187,000	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	(145,000)	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)**	$ 42,000	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)**	$ 1,019,702	24	*

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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,252,018	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,252,018	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***	4,314	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,314	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	40,297	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 40,297	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,296,629	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,067,759	31
32	Health Care	1,570,279	32
33	General Administration	1,408,951	33
	B. Capital Expense		
34	Ownership	1,062,640	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,109,629	40
41	**Income before Income Taxes (line 30 minus line 40)****	187,000	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 187,000	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,705,940	44
45	Private Pay - Net Inpatient Revenue	137,816	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Managed Care	1,405,256	47
48	Other-(specify) Insurance	3,006	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,252,018	49

* **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.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	1,873	2,086	$ 89,309	$ 42.81	1
2	Assistant Director of Nursing	1,353	1,543	44,310	28.72	2
3	Registered Nurses	2,595	2,718	65,882	24.24	3
4	Licensed Practical Nurses	12,666	14,061	308,671	21.95	4
5	CNAs & Orderlies	44,971	48,379	524,273	10.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,027	2,601	26,872	10.33	8
9	Activity Director					9
10	Activity Assistants	14,664	16,199	162,416	10.03	10
11	Social Service Workers	12,884	13,859	206,759	14.92	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,278	18,657	183,856	9.85	15
16	Dishwashers					16
17	Maintenance Workers	3,755	4,074	52,679	12.93	17
18	Housekeepers	17,618	19,295	205,271	10.64	18
19	Laundry					19
20	Administrator	1,767	2,022	79,576	39.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,203	15,287	180,142	11.78	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	1,895	2,061	24,033	11.66	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,764	3,764	15,526	4.12	33
34	TOTAL (lines 1 - 33)	152,313	166,606	$ 2,169,575 *	$ 13.02	34

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

** See instructions.

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	Monthly	$ 9,146	01-03	35
36	Medical Director	Monthly	7,750	09-03	36
37	Medical Records Consultant	Monthly	4,616	10-03	37
38	Nurse Consultant	Monthly	34,800	10-03	38
39	Pharmacist Consultant	Monthly	10,896	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	2,501	11-03	44
45	Social Service Consultant				45
46	Other(specify) Specialized Rehab	Monthly	17,400	10a-03	46
47	Dir of Food Services	Monthly	17,400	01-03	47
48					48
49	TOTAL (lines 35 - 48)		$ 104,509		49

C. CONTRACT NURSES

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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Arleen Menchavez-Siap	Administator	0	$ 79,576
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 79,576

B. Administrative - Other

Description	Amount
SIR Management- Consulting Fees	$ 262,538
SIR Management- Director of Adminstrative Services	34,800
SIR Management- Ancillary Management Charges	34,800
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 332,138

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 12,195
McGladrey	Accounting	2,900
Plante Moran	Accounting	2,050
SIR Management	Bookkeeping	57,420
SIR Management	Dir. Of Regulatory Services	17,400
SIR Management	Dir. Of Financial Services	36,000
Personnel Planners	Uemployment Tax Consult	1,834
Pinnacle Quality Insights	Customer Satisfaction	2,725
HK Payroll Services Co	Payroll	618
Legat Archtects	Architects	1,710
Allscripts	Practice Management	1,041
See Supplemental Schedule		15,522
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 151,415

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 19,566
Unemployment Compensation Insurance	51,071
FICA Taxes	165,416
Employee Health Insurance	112,278
Employee Meals	20,568
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension Plan	16,784
401K Contributions	3,550
Other Employee Benefits	7,094
TOTAL (agree to Schedule V, line 22, col.8)	$ 396,327

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,992
Advertising: Employee Recruitment	2,049
Health Care Worker Background Check (Indicate # of checks performed 365)	3,652
Patient Background Checks	
Dues & Subscriptions	10,643
Licenses & Permits	10,086
Allocated from SIR Management	2,284
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 30,706

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,249
Allocated from SIR Management	641
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,890

**See instructions.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/14 Ending: 12/31/14

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													
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19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. **Alliance for Living $17,883**

(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. $ **408** 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. $
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **20,568** 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? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.