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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0031971

Facility Name: Greenwood Care Ltd.

Address: 1406 N. Chicago Ave. (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) 282-6300
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 01/01/15 to 12/31/15 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)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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 Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	29,606	1,684	16,324	47,614	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,606	1,684	16,324	47,614	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.97%

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: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number Greenwood Care Ltd. # 0031971 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	193,713	20,193	25,370	239,276		239,276	(11,156)	228,120			1
2	Food Purchase		249,016		249,016	(20,312)	228,704	(1,188)	227,516			2
3	Housekeeping	210,925	34,826		245,751		245,751		245,751			3
4	Laundry		9,947	18,033	27,980		27,980		27,980			4
5	Heat and Other Utilities			113,223	113,223		113,223	(11,458)	101,765			5
6	Maintenance	52,899	33,122	132,893	218,914		218,914	3,244	222,158			6
7	Other (specify):*							7,333	7,333			7
8	**TOTAL General Services**	457,537	347,104	289,519	1,094,160	(20,312)	1,073,848	(13,225)	1,060,623			8
	B. Health Care and Programs											
9	Medical Director			6,600	6,600		6,600		6,600			9
10	Nursing and Medical Records	1,058,945	34,581	59,923	1,153,449		1,153,449	(2,361)	1,151,088			10
10a	Therapy	39,444		24,360	63,804		63,804	(11,619)	52,185			10a
11	Activities	132,565	9,658	1,428	143,651		143,651		143,651			11
12	Social Services	199,825			199,825		199,825		199,825			12
13	CNA Training											13
14	Program Transportation			146	146		146		146			14
15	Other (specify):*							5,733	5,733			15
16	**TOTAL Health Care and Programs**	1,430,779	44,239	92,457	1,567,475		1,567,475	(8,247)	1,559,228			16
	C. General Administration											
17	Administrative	75,566		338,804	414,370		414,370	(245,865)	168,505			17
18	Directors Fees											18
19	Professional Services			221,943	221,943	(19,555)	202,388	(146,567)	55,821			19
20	Dues, Fees, Subscriptions & Promotions			60,154	60,154		60,154	(29,313)	30,841			20
21	Clerical & General Office Expenses	194,886	18,373	76,030	289,289		289,289	88,774	378,063			21
22	Employee Benefits & Payroll Taxes			391,324	391,324	20,312	411,636		411,636			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,018	4,018		4,018	1,006	5,024			24
25	Other Admin. Staff Transportation			3,699	3,699		3,699	5,952	9,651			25
26	Insurance-Prop.Liab.Malpractice			100,053	100,053		100,053	10,857	110,910			26
27	Other (specify):*							33,624	33,624			27
28	**TOTAL General Administration**	270,452	18,373	1,196,025	1,484,850	757	1,485,607	(281,532)	1,204,075			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,158,768	409,716	1,578,001	4,146,485	(19,555)	4,126,930	(303,004)	3,823,926			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 Ltd. #0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			41,153	41,153		41,153	152,341	193,494			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,792	7,792		7,792	374,619	382,411			32
33	Real Estate Taxes					19,555	19,555	201,064	220,619			33
34	Rent-Facility & Grounds			1,020,000	1,020,000		1,020,000	(1,020,000)				34
35	Rent-Equipment & Vehicles			6,138	6,138		6,138	5,658	11,796			35
36	Other (specify):*							57,072	57,072			36
37	TOTAL Ownership			1,075,083	1,075,083	19,555	1,094,638	(229,246)	865,392			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)	2,158,768	409,716	2,653,084	5,221,568		5,221,568	(532,250)	4,689,318			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 Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Reference	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	(13,460)	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	(18,940)	30		9
10	Interest and Other Investment Income	(15,481)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(88)	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	(13,333)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(14,023)	21		24
25	Fund Raising, Advertising and Promotional	(8,492)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,850)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(38,557)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (124,223)		$	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)	(408,027)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (408,027)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (532,250)		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 Ltd.

ID# 0031971

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (1,100)	02	1
2	Misc Income	(34)	21	2
3	Theft & Damage	(84)	21	3
4	Bank Fees	(6,804)	21	4
5	Non Allowable Legal Fees	(9,309)	19	5
6	PAC Dues	(8,875)	20	6
7	Bldg Co. - Filing Fees	(350)	21	7
8	Bldg Co. - Office Expense	(12)	21	8
9	Bldg Co. - Professional Fees	(8,300)	19	9
10	Additional R&M	2,094	06	10
11	Capitalized R&M	(5,783)	06	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**	(38,557)		49

Greenwood Care Ltd.

ID# 0031971

Report Period Beginning: 01/01/15

Ending: 12/31/15

	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			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Greenwood Care Ltd. # 0031971 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary				(11,156)								(11,156)	1
2	Food Purchase	(1,188)											(1,188)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(13,460)			2,002								(11,458)	5
6	Maintenance	(3,689)	7,055	(16,680)	16,558								3,244	6
7	Other (specify):*				7,333								7,333	7
8	**TOTAL General Services**	(18,337)	7,055	(16,680)	14,737								(13,225)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(8,996)	6,887	(252)							(2,361)	10
10a	Therapy				(11,619)								(11,619)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			2,987	2,746								5,733	15
16	**TOTAL Health Care and Programs**			(6,009)	(1,986)	(252)							(8,247)	16
	C. General Administration													
17	Administrative			(316,416)	70,551								(245,865)	17
18	Directors Fees													18
19	Professional Services	(17,609)	8,300	(150,669)	13,411								(146,567)	19
20	Fees, Subscriptions & Promotions	(30,700)		1,387									(29,313)	20
21	Clerical & General Office Expenses	(23,157)	362	111,480	89								88,774	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,006									1,006	24
25	Other Admin. Staff Transportation			5,952									5,952	25
26	Insurance-Prop.Liab.Malpractice		8,873	1,790	194								10,857	26
27	Other (specify):*			18,406	15,218								33,624	27
28	**TOTAL General Administration**	(71,466)	17,535	(327,064)	99,463								(281,532)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(89,803)	24,590	(349,753)	112,213	(252)							(303,004)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Greenwood Care Ltd. # 0031971 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(18,940)	165,084		6,197								152,341	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(15,481)	396,582	(11,992)	5,510								374,619	32
33	Real Estate Taxes		193,911		7,153								201,064	33
34	Rent-Facility & Grounds		(1,020,000)										(1,020,000)	34
35	Rent-Equipment & Vehicles			5,658									5,658	35
36	Other (specify):*		57,072										57,072	36
37	**TOTAL Ownership**	(34,421)	(207,351)	(6,334)	18,860								(229,246)	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)**	(124,223)	(182,761)	(356,087)	131,073	(252)							(532,250)	45

Facility Name & ID Number Greenwood Care Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 1,020,000	Greenwood Care LLC	100.00%	$	$ (1,020,000)	1
2	V	32	Interest	114	Greenwood Care LLC	100.00%	396,696	396,582	2
3	V	06	R & M		Greenwood Care LLC	100.00%	7,055	7,055	3
4	V	21	Filing Fees		Greenwood Care LLC	100.00%	350	350	4
5	V	36	Mortgage Insurance		Greenwood Care LLC	100.00%	57,072	57,072	5
6	V	21	Office Expense		Greenwood Care LLC	100.00%	12	12	6
7	V	26	Property Insurance		Greenwood Care LLC	100.00%	8,873	8,873	7
8	V	33	Real Estate Taxes	10,089	Greenwood Care LLC	100.00%	204,000	193,911	8
9	V	30	Depreciation		Greenwood Care LLC	100.00%	165,084	165,084	9
10	V	19	Professional Fees		Greenwood Care LLC	100.00%	8,300	8,300	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,030,203			$ 847,442	$ * (182,761)	14

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

Facility Name & ID Number Greenwood Care Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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.	$ 20,880	S.I.R. MANAGEMENT, INC.	100.00%	$ 4,200	$ (16,680)	15
16	V								16
17	V	10	NURSING	41,760	S.I.R. MANAGEMENT, INC.	100.00%	32,764	(8,996)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	2,987	2,987	18
19	V	19	PROFESSIONAL FEES	154,440	S.I.R. MANAGEMENT, INC.	100.00%	3,390	(151,050)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	1,387	1,387	20
21	V	21	CLERICAL & GENERAL	6,960	S.I.R. MANAGEMENT, INC.	100.00%	106,245	99,285	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	1,006	1,006	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	5,952	5,952	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,790	1,790	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	5,625	5,625	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(11,992)	(11,992)	26
27	V	35	AUTO RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	4,810	4,810	27
28	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	848	848	28
29	V								29
30	V	17	ADMINISTRATIVE	338,804	S.I.R. MANAGEMENT, INC.	100.00%	22,388	(316,416)	30
31	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	381	381	31
32	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	12,195	12,195	32
33	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	12,781	12,781	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 562,844			$ 206,757	$ * (356,087)	39

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

Facility Name & ID Number Greenwood Care Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	$ 6,244	$ (11,156)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	871	871	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	6,887	6,887	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	953	953	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	70,551	70,551	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	13,345	13,345	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	15,218	15,218	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	24,360	S.I.R. MANAGEMENT, INC.	100.00%	12,741	(11,619)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,793	1,793	25
26	V								26
27	V	6	MAINTENANCE SALARIES	27,750	S.I.R. MANAGEMENT, INC.	100.00%	43,183	15,433	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	6,462	6,462	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	2,002	2,002	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	1,125	1,125	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	66	66	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	89	89	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	194	194	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	6,197	6,197	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	5,510	5,510	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	7,153	7,153	37
38	V								38
39	Total			$ 69,510			$ 200,583	$ * 131,073	39

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

Facility Name & ID Number Greenwood Care Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	10	Nursing and Medical Records	$ 19,091	MAC Rx, LLC	100.00%	$ 18,839	$ (252)	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			$ 19,091			$ 18,839	$ * (252)	39

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

Facility Name & ID Number Greenwood Care Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	51.72%	APPLEWOOD REHABILITATION CENTER LLC	MATTESON	ALBANY CARE LLC	LINCOLNWOOD	BUILDING CO.	1
2	DENNIS TOSSI	2.76%	BRYN MAWR CARE INC	CHICAGO	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO	2
3	LOUISE BERGTHOLD	3.45%	COLUMBUS PARK NURSING & REHABILITATION CENTER INC	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	THOMAS WINTER	4.14%	DECATUR MANOR HEALTHCARE LLC	DECATUR	OAKTON ARMS	DES PLAINES	ASSISTED LIVING	4
5	MICHAEL R. GIANNINI TRUST DTD 3/13/00	3.45%	ELMWOOD CARE INC	ELMWOOD PARK	MAC Rx LLC	DES PLAINES	PHARMACY CONSULTANT	5
6	CELESTE GIANNINI TRUST DTD 3/13/00	3.45%	ALBANY CARE INC	EVANSTON				6
7	JULIANA R BARRISH TRUST DTD 1/26/93	15.52%	NEIGHBORS REHABILTATION CENTER LLC	BYRON				7
8	BRYAN BARRISH TRUST DTD 9/01/04	15.52%	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 Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	2.64	5.87%	Alloc. Salary	$ 13,204	17-7	1
2	Kirsten Schloss	Relative	Maintenance		See Attached	3.30	6.60%	Alloc. Salary	6,359	6-7	2
3	Sarah Barrish	Relative	Administrative		See Attached	2.97	6.60%	Alloc. Salary	6,955	17-7	3
4	Louise Bergthold	Owner	Administrative	3.45%	See Attached	3.96	6.60%	Alloc. Salary	13,204	17-7	4
5	Michael Giannini	Relative	Administrative		See Attached	2.31	5.78%	Alloc. Salary	11,288	17-7	5
6	Nenita Guzman	Relative	Dietary		See Attached	3.30	6.60%	Alloc. Salary	6,244	1-7	6
7	Tom Winter	Owner	Administrative	4.14%	See Attached	3.96	6.60%	Alloc. Salary	13,204	17-7	7
8	Thomas Bergthold	Relative	Clerical		See Attached	2.64	6.60%	Alloc. Salary	2,729	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	$ 73,187		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 Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	721,222	14	$ 63,617	$	47,614	$ 4,200	1
2										2
3	10	NURSING	PATIENT DAYS	721,222	14	496,290	496,290	47,614	32,764	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	721,222	14	45,246		47,614	2,987	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	721,222	14	51,349		47,614	3,390	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	721,222	14	21,010		47,614	1,387	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	721,222	14	1,609,327	1,193,369	47,614	106,245	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	721,222	14	15,238		47,614	1,006	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	721,222	14	90,162		47,614	5,952	9
10	26	INSURANCE	PATIENT DAYS	721,222	14	27,120		47,614	1,790	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	721,222	14	85,206		47,614	5,625	11
12	32	INTEREST	PATIENT DAYS	721,222	14	(181,648)		47,614	(11,992)	12
13	35	AUTO RENTAL	PATIENT DAYS	721,222	14	72,863		47,614	4,810	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	721,222	14	12,850		47,614	848	14
15										15
16	17	ADMINISTRATIVE	PATIENT DAYS	721,222	14	339,119	339,119	47,614	22,388	16
17	19	PROFESSIONAL FEES	PATIENT DAYS	721,222	14	5,774		47,614	381	17
18	21	CLERICAL & GENERAL	PATIENT DAYS	721,222	14	184,716	77,164	47,614	12,195	18
19	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	721,222	14	193,599		47,614	12,781	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,131,838	$ 2,105,942		$ 206,757	25

Facility Name & ID Number Greenwood Care Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	721,222	14	$ 94,587	$ 94,587	47,614	$ 6,244	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	721,222	14	13,188		47,614	871	2
3	10	NURSING SALARIES	PATIENT DAYS	721,222	14	104,315	104,315	47,614	6,887	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	721,222	14	14,440		47,614	953	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	721,222	14	1,068,659	1,068,659	47,614	70,551	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	721,222	14	202,147		47,614	13,345	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	721,222	14	230,505		47,614	15,218	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	322,920	13	168,894	168,894	24,360	12,741	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	322,920	13	23,767		24,360	1,793	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	319,657	14	497,427	497,427	27,750	43,183	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	319,657	14	74,439		27,750	6,462	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,878	14	30,338		850	2,002	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,878	14	17,037		850	1,125	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,878	14	1,002		850	66	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,878	14	1,351		850	89	19
20	26	INSURANCE	ALLOCATED SQ FT	12,878	14	2,937		850	194	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,878	14	93,883		850	6,197	21
22	32	INTEREST	ALLOCATED SQ FT	12,878	14	83,486		850	5,510	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,878	14	108,372		850	7,153	23
24										24
25	TOTALS					$ 2,830,774	$ 1,933,882		$ 200,583	25

Facility Name & ID Number Greenwood Care Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: MAC Rx, LLC
Street Address: 2307 S. Mount Prospect Road
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (224)220-2700
Fax Number: (224)220-2730

	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	10	Nursing And Medical Records	Direct Allocation			$	$		$ 18,839	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					$	$		$ 18,839	25

Facility Name & ID Number Greenwood Care Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			$	$ 11,232,838			$ 396,696	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Lake Forst Bank		X	Line of Credit				300,000			7,792	6
7	Allocated from SIR Managemen	X									5,510	7
8												8
9	TOTAL Facility Related						$	$ 11,532,838			$ 409,998	9
	B. Non-Facility Related*											
10	Interest Income		X								(15,481)	10
11	Interest Income - Bldg Co		X								(114)	11
12	Allocated from SIR Managemen	X									(11,992)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (27,587)	14
15	TOTALS (line 9+line14)						$	$ 11,532,838			$ 382,412	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 57,072 **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 Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Ltd. # 0031971 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	204,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	201,064	2
3. Under or (over) accrual (line 2 minus line 1).	$	(2,936)	3
4. Real Estate Tax accrual used for 2015 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.**	$	19,555	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** $ 58,614 **For** 2011 & **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.	$	220,619	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2010	178,650	8
2011	179,522	9
2012	188,087	10
2013	193,972	11
2014	193,911	12

2014 Accrual = $193911 x 1.05 = $204,000 (Rounded)
Allocated from SIR Management = $7,153

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Greenwood Care Ltd. 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 2014 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 2014.

	(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	$ 193,910.98	$ 193,910.98
2.	See Attached	Allocated from SIR	$ 118,674.75	$ 6,134.47
3.	See Attached	Allocated from Regency	$ 862,948.02	$ 691.47
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,175,533.75	$ 200,736.92

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 Ltd. 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 Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 165,084	35	$	$ (165,084)	$ 1,845,500	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1984	2,672		20	76	76	2,260	9
10	Various			1987	24,869		20	694	694	21,204	10
11	Various			1988	27,733		20	321	321	20,640	11
12	Various			1989	7,668		20	87	87	5,853	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			20,315	16
17	Various			1995	73,839		20	1,503	1,503	73,839	17
18	Various			1996	109,220		20	5,461	5,461	106,770	18
19	Various			1997	73,171		20	3,659	3,659	67,705	19
20	Various			1998	58,371		20	2,919	2,919	51,013	20
21	Various			1999	179,834		20	9,098	9,098	150,224	21
22	Various			2000	171,876		20	8,594	8,594	134,997	22
23	Various			2001	43,730		20	2,187	2,187	32,463	23
24	Various			2002	87,606		20	3,432	3,432	64,742	24
25	Various			2003	59,109		20	1,707	1,707	45,816	25
26	Various			2004	77,107		20	3,142	3,142	50,833	26
27	Various			2005	58,861		20	3,045	3,045	33,921	27
28	Various			2006	271,462		20	13,573	13,573	129,592	28
29	Various			2007	153,877		20	8,049	8,049	69,846	29
30	Various			2008	29,039		20	1,452	1,452	10,773	30
31	Various			2009	36,735		20	1,837	1,837	12,105	31
32	Various			2010	11,568		20	1,157	1,157	5,880	32
33	Various			2011	11,264		20	826	826	4,011	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 Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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)		1,556,815			77,309	77,309	502,820	67
68	Related Party Allocations (Pages 12H & 12I)		144,494	3,848		5,007	1,159	73,865	68
69	Financial Statement Depreciation			41,153			(41,153)		69
70	TOTAL (lines 4 thru 69)		$ 5,235,475	$ 210,085		$ 155,133	$ (54,952)	$ 3,635,146	70

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

Facility Name & ID Number Greenwood Care Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 5,235,475	$ 210,085		$ 155,133	$ (54,952)	$ 3,635,146	1
2	Electric Wiring	2012	22,000		20	1,100	1,100	4,400	2
3	Elevator Recall System	2012	14,490		20	725	725	2,657	3
4	Remodel 5Th Floor Shower Room	2012	10,400		20	520	520	1,907	4
5	Stairwell Railing	2012	6,580		20	658	658	2,029	5
6	Sprinkler System Repair	2012	2,706		20	135	135	440	6
7	Sprinkler System Work	2013	6,322		20	316	316	790	7
8	Walk In Cooler Repair	2015	2,983		20	149	149	149	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)		$ 5,300,956	$ 210,085		$ 158,737	$ (51,348)	$ 3,647,517	34

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

Facility Name & ID Number Greenwood Care Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 5,300,956	$ 210,085		$ 158,737	$ (51,348)	$ 3,647,517	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)		$ 5,300,956	$ 210,085		$ 158,737	$ (51,348)	$ 3,647,517	34

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

Facility Name & ID Number Greenwood Care Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 5,300,956	$ 210,085		$ 158,737	$ (51,348)	$ 3,647,517	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)		$ 5,300,956	$ 210,085		$ 158,737	$ (51,348)	$ 3,647,517	34

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

Facility Name & ID Number Greenwood Care Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 5,300,956	$ 210,085		$ 158,737	$ (51,348)	$ 3,647,517	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)		$ 5,300,956	$ 210,085		$ 158,737	$ (51,348)	$ 3,647,517	34

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

Facility Name & ID Number Greenwood Care Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Building Company		$	$		$	$	$	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	92,280	9
10	Various	2009	571,486		20	24,434	24,434	170,947	10
11	Boiler System	2010	72,862		20	3,643	3,643	21,858	11
12	FL 2 Shower Room- Wall Work, Concrete, Rubber Pan, Tiles	2010	6,700		20	670	670	4,020	12
13	First Floor- Doors, wall work, replace ceiling tiles, carpet, tile	2010	140,819		20	7,041	7,041	42,246	13
14	Painting- First Floor	2010	27,225		20	1,361	1,361	8,166	14
15	Flooring 2-3	2010	17,238		20	862	862	5,172	15
16	Lintel Work	2010	21,500		20	1,075	1,075	6,450	16
17	Resident Door Locks	2010	7,297		20	365	365	2,190	17
18	Electric- basement closet & lighting, utility room	2010	4,498		20	225	225	1,350	18
19	Kitchen Ceiling	2010	5,320		20	266	266	1,596	19
20	FL 4 Shower Room- Wall Work, Concrete, Rubber Pan, Tiles	2010	18,200		20	910	910	5,460	20
21	Wallpaper- First Floor & Conference Room	2010	8,175		20	409	409	2,454	21
22	FL1 Front, 2 Hallway Bath- ceiling, doors, hardware, toilet	2010	15,503		20	775	775	4,650	22
23	Window Openings- Remodeling, Plaster, Drywall	2010	7,200		20	360	360	2,160	23
24	First Floor Remodeling- Wallpaper, Tiles	2010	9,512		20	476	476	2,856	24
25	Oxygen Room- Replace vinyle flooring, duct work	2010	13,250		20	1,325	1,325	7,950	25
26	Elevator Panels	2010	2,900		20	290	290	1,740	26
27	Rooftop Fence/Coping	2010	11,690		20	585	585	3,510	27
28	Window Replacement	2010	81,115		20	4,056	4,056	24,336	28
29	Elevator Motor	2010	5,600		20	280	280	1,680	29
30	Fire Doors	2010	3,260		20	326	326	1,956	30
31	Replace antenae system with cable TV	2010	11,007		20	863	863	5,178	31
32	Fire Doors	2010	2,650		20	265	265	1,590	32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,295,713	$		$ 62,397	$ 62,397	$ 421,795	34

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

Facility Name & ID Number Greenwood Care Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 421,795	1
2	Window Treatments	2010	29,426		20	2,943	2,943	17,658	2
3	Window Treatments	2010	3,103		20	310	310	1,860	3
4	Handrails	2010	22,860		20	1,143	1,143	6,858	4
5	Window Treatments- Dining Room	2010	4,611		20	461	461	2,766	5
6	Rail and Guards- Dining Rooms	2010	3,984		20	199	199	1,194	6
7	Condenser Fan/Outlet	2010	2,579		20	129	129	774	7
8	Steampipe Work- Water Leaks	2010	2,580		20	129	129	774	8
9	Regrout Kitchen Floor	2010	2,862		20	143	143	858	9
10	Roof Repairs & Coating	2010	2,980		20	149	149	894	10
11	Wall Base Repairs	2010	6,267		20	313	313	1,878	11
12	Tuckpointing	2010	5,500		20	275	275	1,650	12
13	Parapet Repairs	2010	6,500		20	325	325	1,950	13
14	Grease Interceptor & Floor Drain	2011	7,400		20	370	370	1,850	14
15	Coffee Shop Custom Cabinet	2011	3,000		20	150	150	750	15
16	Painting of Entire Facility	2010	107,900		20	5,395	5,395	32,370	16
17	Duct extensions- community bathrooms	2012	5,321		20	266	266	1,064	17
18	Sprinkler System Repair	2012	3,367		20	168	168	672	18
19	Boiler Repair	2012	3,326		20	166	166	664	19
20	Kitchen-patch walls and paint	2012	3,700		20	185	185	740	20
21	Elevator Generator	2013	5,500		20	275	275	825	21
22	Nurse Call Annuciator	2013	8,331		20	417	417	1,251	22
23	Camera Security System	2013	7,230		20	362	362	1,086	23
24	Mounted Firedoor Holders	2015	6,340		20	317	317	317	24
25	Replace Radiant Heat Lines	2015	6,435		20	322	322	322	25
26									26
27	Building Company Depreciation								27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,556,815	$		$ 77,309	$ 77,309	$ 502,820	34

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

Facility Name & ID Number Greenwood Care Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	SIR Properties - SIR Management	1993	29,878	948	35	854	(94)	19,207	3
4	SIR Management	2009	33,002	846	39	846		5,113	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Alloc. - S.I.R. Management	1993	7,575	211	20		(211)	7,575	9
10	Alloc. - S.I.R. Management	1994	24		20			24	10
11	Alloc. - S.I.R. Management	1995	173		20	5	5	173	11
12	Alloc. - S.I.R. Management	1997	11,639	261	20	567	306	10,877	12
13	Alloc. - S.I.R. Management	1999	915		20	46	46	743	13
14	Alloc. - S.I.R. Management	1999	8,112		20			8,112	14
15	Alloc. - S.I.R. Management	2000	1,081		20	54	54	840	15
16	Alloc. - S.I.R. Management	2007	3,472		20	174	174	1,422	16
17	Alloc. - S.I.R. Management	2008	9,568	957	20	603	(354)	4,731	17
18	Alloc. - S.I.R. Management	2009	23,775	217	20	1,189	972	7,423	18
19	Alloc. - S.I.R. Management	2011	588	59	20	59		260	19
20	Alloc. - S.I.R. Management	2012	1,882	94	20	94		322	20
21	Alloc. - S.I.R. Management	2014	264	26	20	13	(13)	21	21
22									22
23	Alloc. - S.I.R. Properties - S.I.R. Management	2012	1,830	129	20	6	(123)	33	23
24	Alloc. - S.I.R. Properties - S.I.R. Management	2010	1,803		20	90	90	481	24
25	Alloc. - S.I.R. Properties - S.I.R. Management	2009	1,794	80	20	90	10	610	25
26	Alloc. - S.I.R. Properties - S.I.R. Management	2007	523	10	20	26	16	235	26
27	Alloc. - S.I.R. Properties - S.I.R. Management	2002	118		20	6	6	80	27
28	Alloc. - S.I.R. Properties - S.I.R. Management	1999	3,786		20	189	189	3,123	28
29	Alloc. - S.I.R. Properties - S.I.R. Management	1998	1,809		20	90	90	1,583	29
30	Alloc. - S.I.R. Properties - S.I.R. Management	1997	113		20	6	6	107	30
31	Alloc. - S.I.R. Properties - S.I.R. Management	1994	285	7	20		(7)	285	31
32	Alloc. - S.I.R. Properties - S.I.R. Management	1993	485	3	20		(3)	485	32
33									33
34	TOTAL (lines 1 thru 33)		$ 144,494	$ 3,848		$ 5,007	$ 1,159	$ 73,865	34

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

Facility Name & ID Number Greenwood Care Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		$ 144,494	$ 3,848		$ 5,007	$ 1,159	$ 73,865	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)		$ 144,494	$ 3,848		$ 5,007	$ 1,159	$ 73,865	34

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

Facility Name & ID Number Greenwood Care Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 603,254	$ 2,145	$ 34,225	$ 32,080	10	$ 461,865	71
72	Current Year Purchases	2,800		280	280	10	280	72
73	Fully Depreciated Assets	222,721		4	4	10	222,721	73
74								74
75	TOTALS	$ 828,775	$ 2,145	$ 34,509	$ 32,364		$ 684,866	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	2015	2,320	203	248	45	5	1,585	77
78										78
79										79
80	TOTALS			$ 16,457	$ 203	$ 248	$ 45		$ 15,722	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)	$ 6,298,743	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 212,433	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 193,493	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (18,940)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,348,105	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 Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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.	/2016	$
13.	/2017	$
14.	/2018	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 6,986 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		$	$ 4,810	17
18					18
19					19
20					20
21	TOTAL		$	$ 4,810	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 Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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		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 Ltd. # 0031971 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/15 (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	$ 63,096	$ 164,464	1
2	Cash-Patient Deposits	21,091	21,091	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	690,183	690,183	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,175	48,559	6
7	Other Prepaid Expenses	941	941	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)**	$ 1,002,486	$ 1,125,238	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	2,387,333	15
16	Equipment, at Historical Cost	1,002,644	1,470,793	16
17	Accumulated Depreciation (book methods)	(1,367,983)	(3,895,325)	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):		358,267	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 705,475	$ 2,747,685	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,707,961	$ 3,872,923	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 141,872	$ 141,872	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,091	21,091	28
29	Short-Term Notes Payable	300,000	300,000	29
30	Accrued Salaries Payable	155,557	155,557	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,520	10,520	31
32	Accrued Real Estate Taxes(Sch.IX-B)		204,000	32
33	Accrued Interest Payable		32,762	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	14,740	14,740	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 643,780	$ 880,542	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,232,838	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43			730,412	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 11,963,250	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 643,780	$ 12,843,792	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,064,181	$ (8,970,869)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,707,961	$ 3,872,923	48

***(See instructions.)**

Facility Name & ID Number Greenwood Care Ltd. # 0031971 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,019,702	1
2	Restatements (describe):		2
3	Rounding	5	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,019,707	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	102,474	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	(58,000)	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)**	$ 44,474	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)**	$ 1,064,181	24 *

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

Facility Name & ID Number Greenwood Care Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 5,245,563	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,245,563	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***	15,481	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 15,481	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	62,998	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 62,998	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,324,042	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,094,160	31
32	Health Care	1,567,475	32
33	General Administration	1,484,850	33
	B. Capital Expense		
34	Ownership	1,075,083	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)***	$ 5,221,568	40
41	**Income before Income Taxes (line 30 minus line 40)****	102,474	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 102,474	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,223,641	44
45	Private Pay - Net Inpatient Revenue	236,351	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Managed Care	1,785,571	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,245,563	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 Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	1,942	2,078	$ 91,105	$ 43.84	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,441	2,588	68,419	26.44	3
4	Licensed Practical Nurses	13,875	15,659	347,517	22.19	4
5	CNAs & Orderlies	44,209	47,676	511,886	10.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,632	3,047	39,444	12.95	8
9	Activity Director					9
10	Activity Assistants	13,609	14,617	132,565	9.07	10
11	Social Service Workers	12,583	13,726	199,825	14.56	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,633	18,013	193,713	10.75	15
16	Dishwashers					16
17	Maintenance Workers	3,584	4,084	52,899	12.95	17
18	Housekeepers	18,125	19,934	210,925	10.58	18
19	Laundry					19
20	Administrator	1,772	1,857	75,566	40.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,364	14,551	177,327	12.19	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,436	2,697	40,018	14.84	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	4,257	4,257	17,558	4.12	33
34	TOTAL (lines 1 - 33)	151,462	164,784	$ 2,158,767 *	$ 13.10	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	$ 7,970	01-03	35
36	Medical Director	Monthly	6,600	09-03	36
37	Medical Records Consultant	Monthly	3,144	10-03	37
38	Nurse Consultant	Monthly	41,760	10-03	38
39	Pharmacist Consultant	Monthly	15,019	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	1,428	11-03	44
45	Social Service Consultant				45
46	Other(specify) Specialized Rehab	Monthly	24,360	10a-03	46
47	Dir of Food Services	Monthly	17,400	3-Jan	47
48					48
49	TOTAL (lines 35 - 48)		$ 117,681		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 Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Arleen Menchavez-Siap	Administator	0	$ 9,642
Laurie M. Evans	Administator	0	65,924
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 75,566

B. Administrative - Other

Description	Amount
SIR Management- Consulting Fees	$ 262,244
SIR Management- Director of Adminstrative Services	41,760
SIR Management- Ancillary Administrative Charges	34,800
TOTAL (agree to Schedule V, line 17, col. 3)	$ 338,804
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR&R/Marcum	Accounting	$ 18,675
McGladrey	Accounting	1,455
SIR Management	Bookkeeping	60,900
SIR Management	Dir. Of Regulatory Services	20,880
SIR Management	Dir. Of Financial Services	39,600
Personnel Planners	Uemployment Tax Consult	1,162
Pinnacle Quality Insights	Customer Satisfaction	2,754
Paychex	Payroll	14,731
Legat Archtects	Architects	3,428
Allscripts	Practice Management	4,507
See Attached	Legal Fees	29,490
See Supplemental Schedule		24,360
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 221,942

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 30,985
Unemployment Compensation Insurance	53,948
FICA Taxes	164,947
Employee Health Insurance	108,609
Employee Meals	20,312
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension Plan	20,956
401K Contributions	3,600
Other Employee Benefits	8,280
TOTAL (agree to Schedule V, line 22, col.8)	$ 411,636

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	1,000
Health Care Worker Background Check	
(Indicate # of checks performed 675)	6,752
Patient Background Checks	
Dues & Subscriptions	10,179
Licenses & Permits	9,531
Allocated from SIR Management	1,387
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 30,841

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,018
Allocated from SIR Management	1,006
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,024

**See instructions.

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

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

Facility Name & ID Number Greenwood Care Ltd. # 0031971 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 $18,804**

(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. $ **413** 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. $ **20,312** 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.