

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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.

I. IDPH License ID Number: <u>0031971</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Greenwood Care Ltd.</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/11</u> to <u>12/31/11</u> 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.																							
Address: <u>1406 N. Chicago Ave.</u> <u>Evanston</u> <u>60201</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(847) 328-7508</u> Fax # <u>(847) 869-4878</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Cary Drazner, C.P.A.</u></td></tr><tr><td>(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Print Name and Title) <u>Cary Drazner, C.P.A.</u>	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	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												
Officer or Administrator of Provider	(Signed) _____																								
	(Type or Print Name) _____																								
	(Title) _____																								
	(Signed) _____																								
Paid Preparer	(Print Name and Title) <u>Cary Drazner, C.P.A.</u>																								
	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>																								
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>																								
	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																								
Date of Initial License for Current Owners: <u>01/01/90</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☒ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☒ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																							
☐ Charitable Corp.	☐ Individual	☐ State																							
☐ Trust	☐ Partnership	☐ County																							
IRS Exemption Code _____	☐ Corporation	☐ Other _____																							
	☒ "Sub-S" Corp.	_____																							
	☐ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:																									
Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236-1111</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care Ltd.

0031971 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	48,431	476		48,907	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,431	476		48,907	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.41%

D. How many bed-hold days during this year were paid by the Department? 1,923 (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 ☒

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

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

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 02/01/1987 NO ☐

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number Greenwood Care Ltd. # 0031971 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	184,238	27,696	26,904	238,838		238,838	(12,063)	226,775			1
2	Food Purchase		232,166		232,166	(18,524)	213,642	(22)	213,620			2
3	Housekeeping	199,587	29,024		228,611		228,611	(908)	227,703			3
4	Laundry		12,243	11,852	24,095		24,095	(12)	24,083			4
5	Heat and Other Utilities			105,096	105,096		105,096	1,284	106,380			5
6	Maintenance	49,730	37,207	98,796	185,733		185,733	(11,057)	174,676			6
7	Other (specify):*							3,727	3,727			7
8	TOTAL General Services	433,555	338,336	242,648	1,014,539	(18,524)	996,015	(19,052)	976,963			8
	B. Health Care and Programs											
9	Medical Director			7,800	7,800		7,800		7,800			9
10	Nursing and Medical Records	1,158,647	43,750	88,731	1,291,128		1,291,128	(19,790)	1,271,338			10
10a	Therapy			17,400	17,400		17,400	(10,615)	6,785			10a
11	Activities	175,697	14,055	3,738	193,490		193,490		193,490			11
12	Social Services	232,068			232,068		232,068		232,068			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							4,061	4,061			15
16	TOTAL Health Care and Programs	1,566,412	57,805	117,669	1,741,886		1,741,886	(26,344)	1,715,542			16
	C. General Administration											
17	Administrative	81,763		451,930	533,693		533,693	(375,731)	157,962			17
18	Directors Fees											18
19	Professional Services			145,822	145,822	(686)	145,136	(100,830)	44,306			19
20	Dues, Fees, Subscriptions & Promotions			37,842	37,842		37,842	(18,859)	18,983			20
21	Clerical & General Office Expenses	184,692	25,747	74,942	285,381		285,381	58,175	343,556			21
22	Employee Benefits & Payroll Taxes			416,435	416,435	18,524	434,959		434,959			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,025	3,025		3,025	12	3,037			24
25	Other Admin. Staff Transportation			3,205	3,205		3,205	6,993	10,198			25
26	Insurance-Prop.Liab.Malpractice			95,679	95,679		95,679	8,209	103,888			26
27	Other (specify):*							31,160	31,160			27
28	TOTAL General Administration	266,455	25,747	1,228,880	1,521,082	17,838	1,538,920	(390,871)	1,148,049			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,266,422	421,888	1,589,197	4,277,507	(686)	4,276,821	(436,268)	3,840,554			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			44,738	44,738		44,738	261,040	305,778			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,205	14,205		14,205	579,580	593,785			32
33	Real Estate Taxes			212	212	686	898	239,188	240,086			33
34	Rent-Facility & Grounds			1,026,000	1,026,000		1,026,000	(1,026,000)				34
35	Rent-Equipment & Vehicles			5,939	5,939		5,939	5,090	11,029			35
36	Other (specify):*							60,307	60,307			36
37	TOTAL Ownership			1,091,094	1,091,094	686	1,091,780	119,205	1,210,985			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			79,388	79,388		79,388		79,388			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			79,388	79,388		79,388		79,388			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,266,422	421,888	2,759,679	5,447,989	0	5,447,989	(317,062)	5,130,927			45

THE TOTAL FOR COLUMN 5 MUST BE ZERO,PLEASE CORRECT

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(606)	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	94,347	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(22)	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	(4,940)	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	(8,239)	21		24
25	Fund Raising, Advertising and Promotional	(3,572)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,800)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(36,353)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 38,815		\$	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)	(355,877)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (355,877)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (317,062)		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

Report Period Beginning:

ID#0031971

Ending:

01/01/11

12/31/11

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Bank Fees	\$ (5,896)	21	1
2	Theft & Damage	(1,217)	21	2
3	Non-Allowable Legal	(4,118)	19	3
4	Additional R&M	3,796	06	4
5	Capitalized R&M	(5,261)	06	5
6	Alliance for Living - PAC Dues	(11,197)	20	6
7	Non-Allowable Seminar for 2012	(495)	24	7
8				8
9	Building Company:			9
10	Amortization	(4,041)	36	10
11	Office Expense	(5)	21	11
12	Professional Fees	(7,500)	19	12
13	Filing Fees	(350)	21	13
14				14
15	Misc. Income	(69)	21	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	(36,353)		49

Greenwood Care Ltd.

Report Period Beginning:

Ending:

ID#

0031971

01/01/11

12/31/11

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

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 Page 6 Supplemental		See Page 6 Supplemental		See Page 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.

☒

YES

☐

NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 1,026,000	Greenwood Care, LLC	100.00%	\$	\$ (1,026,000)	1
2	V	32	Interest Income	179	Greenwood Care, LLC	100.00%		(179)	2
3	V	36	Amortization of HUD Fees		Greenwood Care, LLC	100.00%	4,041	4,041	3
4	V	30	Depreciation		Greenwood Care, LLC	100.00%	160,656	160,656	4
5	V	21	Filing Fees		Greenwood Care, LLC	100.00%	350	350	5
6	V	32	Mortgage Interest		Greenwood Care, LLC	100.00%	580,945	580,945	6
7	V	36	Mortgage Insurance		Greenwood Care, LLC	100.00%	60,307	60,307	7
8	V	19	Professional Fees		Greenwood Care, LLC	100.00%	7,500	7,500	8
9	V	21	Office Expense		Greenwood Care, LLC	100.00%	5	5	9
10	V	26	Property Insurance		Greenwood Care, LLC	100.00%	7,064	7,064	10
11	V	33	RE Tax Expense		Greenwood Care, LLC	100.00%	234,439	234,439	11
12	V								12
13	V								13
14	Total			\$ 1,026,179			\$ 1,055,307	\$ * 29,128	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS AND MAINT.	\$ 17,400	S.I.R. MANAGEMENT, INC.	100.00%	\$ 7,767	\$ (9,633)	15
16	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	617	617	16
17	V	10	NURSING	34,800	S.I.R. MANAGEMENT, INC.	100.00%	11,371	(23,429)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	1,954	1,954	18
19	V	19	PROFESSIONAL FEES	117,780	S.I.R. MANAGEMENT, INC.	100.00%	9,305	(108,475)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	850	850	20
21	V	21	CLERICAL & GENERAL	34,800	S.I.R. MANAGEMENT, INC.	100.00%	38,259	3,459	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	507	507	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	6,993	6,993	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,056	1,056	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	3,355	3,355	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(6,391)	(6,391)	26
27	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	5,090	5,090	27
28	V								28
29	V	17	ADMINISTRATIVE	451,930	S.I.R. MANAGEMENT, INC.	100.00%	19,465	(432,465)	29
30	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	1,398		30
31	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	71,885	71,885	31
32	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	14,995	14,995	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 656,710			\$ 188,476	\$ * (469,632)	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	\$ 17,400	S.I.R. MANAGEMENT, INC.	100.00%	\$ 5,337	\$ (12,063)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	928	928	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	5,552	5,552	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	961	961	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	56,734	56,734	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	11,036	11,036	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	12,810	12,810	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	17,400	S.I.R. MANAGEMENT, INC.	100.00%	6,785	(10,615)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,146	1,146	25
26	V								26
27	V	6	MAINTENANCE SALARIES	11,615	S.I.R. MANAGEMENT, INC.	100.00%	10,883	(732)	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	2,182	2,182	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	1,890	1,890	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	773	773	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	41	41	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	52	52	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	89	89	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	6,037	6,037	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	5,205	5,205	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	4,749	4,749	37
38	V	19	PROFESSIONAL FEES (RE TAX)		S.I.R. MANAGEMENT, INC.	100.00%	686	686	38
39	Total			\$ 46,415			\$ 133,876	\$ * 87,461	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Xcel Supply, LLC	100.00%	\$	\$	15
16	V	3	Housekeeping	14,983	Xcel Supply, LLC	100.00%	14,075	(908)	16
17	V	4	Laundry	197	Xcel Supply, LLC	100.00%	185	(12)	17
18	V	6	Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10	Nursing	31,558	Xcel Supply, LLC	100.00%	29,645	(1,913)	19
20	V	11	Activities		Xcel Supply, LLC	100.00%			20
21	V	21	Office And Clerical		Xcel Supply, LLC	100.00%			21
22	V	22	Employee Benefits		Xcel Supply, LLC	100.00%			22
23	V	30	Fixed Assets-Depreciation		Xcel Supply, LLC	100.00%			23
24	V	39	Ancillary		Xcel Supply, LLC	100.00%			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			\$ 46,739			\$ 43,905	\$ * (2,833)	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 159,564	\$ 159,564	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	159,564	CSS Employee Benefits Group	100.00%		(159,564)	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			\$ 159,564			\$ 159,564	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	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

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	BRYAN BARRISH TRUST DTD 9/01/04	15.517%	ALBANY CARE INC	EVANSTON	GREENWOOD CARE, LLC	LINCOLNWOOD	BUILDING CO.	1
2	CELESTE GIANNINI TRUST DTD 3/13/00	3.448%	BRYN MAWR CARE INC.	CHICAGO	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	2
3	DENNIS TOSSI	2.759%	COLUMBUS PARK NURSING & REHABILITATION CENTER, INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	ERIC ROTHNER	51.724%	DECATUR MANOR HEALTHCARE,LLC	DECATUR	XCEL MEDICAL SUPPLY, LLC	EVANSTON	SUPPLIES	4
5	JULIANA R. BARRISH TRUST DTD 1/26/93	15.517%	ELMWOOD CARE, INC.	ELMWOOD PARK	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	5
6	LOUISE BERGTHOLD	3.448%	FAIRVIEW NURSING PLAZA, INC.	ROCKFORD				6
7	MICHAEL R. GIANNINI TRUST DTD	3.448%	MAPLEWOOD CARE, INC.	ELGIN				7
8	THOMAS WINTER	4.138%	NEIGHBORS REHABILITATION CENTER,LLC	BYRON				8
9			REGENCY REHABILITATION CENTER,LLC	NILES				9
10			ROCK ISLAND NURSING & REHAB CENTER,LLC	ROCK ISLAND				10
11			WILSON CARE, INC.	CHICAGO				11
12			APPLEWOOD REHABILITATION CENTER	MATTESON				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: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Michael Giannini	Owner	Administrative	3.45%	See Attached	2.04	5.10%	Alloc. Salary	\$ 9,751	17-7	1
2	Bryan Barrish	Owner	Administrative	15.52%	See Attached	2.34	5.20%	Alloc. Salary	11,678	17-7	2
3	Kirsten Barrish	Relative	Clerical	0.00%	See Attached	2.34	5.85%	Alloc. Salary	2,629	21-7	3
4	Sarah Barrish	Relative	Administrative	0.00%	See Attached	2.92	5.84%	Alloc. Salary	6,992	17-7	4
5	Nenita Guzman	Relative	Dietary	0.00%	See Attached	2.92	5.84%	Alloc. Salary	5,337	1-7	5
6	Louise Bergthold	Owner	Administrative	3.45%	See Attached	0.7	1.17%	Alloc. Salary	2,453	17-7	6
7	Tom Winter	Owner	Administrative	4.14%	See Attached	3.5	5.83%	Alloc. Salary	11,678	17-7	7
8	Adam Vales	Relative	Clerical	0.00%	See Attached	0.95	2.38%	Alloc. Salary	1,687	22-7	8
9	G. Matt Silvers	Relative	Administrative	0.00%	See Attached	0.15	0.38%	Alloc. Salary	586	17-7	9
10	Eric Rothner	Shareholder	Administrative	51.72%	See Attached	0.35	0.75%	Alloc. Salary	7,959	17-7	10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect amounts anticipated to be										11
12	considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 60,750		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care Ltd. # 0031971 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Greenwood Care Ltd. # 0031971 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	6	REPAIRS AND MAINT.	PATIENT DAYS	837,569	13	\$ 133,007	\$ 59,965	48,907	\$ 7,767	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	837,569	13	10,563		48,907	617	2
3	10	NURSING	PATIENT DAYS	837,569	13	194,733	194,733	48,907	11,371	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	837,569	13	33,459		48,907	1,954	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	837,569	13	159,360	132,109	48,907	9,305	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	837,569	13	14,549		48,907	850	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	837,569	13	655,215	586,698	48,907	38,259	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	837,569	13	8,688		48,907	507	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	837,569	13	119,765		48,907	6,993	9
10	26	INSURANCE	PATIENT DAYS	837,569	13	18,080		48,907	1,056	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	837,569	13	57,453		48,907	3,355	11
12	32	INTEREST	PATIENT DAYS	837,569	13	(109,444)		48,907	(6,391)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	837,569	13	87,163		48,907	5,090	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	837,569	13	333,346	333,346	48,907	19,465	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	837,569	13	23,941		48,907	1,398	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	837,569	13	1,231,079	1,128,775	48,907	71,885	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	837,569	13	256,807		48,907	14,995	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,227,764	\$ 2,435,627		\$ 188,476	25

Facility Name & ID Number Greenwood Care Ltd. # 0031971 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	837,569	13	\$ 91,408	\$ 91,408	48,907	\$ 5,337	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	837,569	13	15,892		48,907	928	2
3	10	NURSING SALARIES	PATIENT DAYS	837,569	13	95,082	95,082	48,907	5,552	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	837,569	13	16,460		48,907	961	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	837,569	13	971,606	971,606	48,907	56,734	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	837,569	13	189,000		48,907	11,036	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	837,569	13	219,385		48,907	12,810	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	315,820	13	123,146	123,146	17,400	6,785	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	315,820	13	20,802		17,400	1,146	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	367,402	13	344,256	344,256	11,615	10,883	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	367,402	13	69,007		11,615	2,182	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,880	13	32,378		752	1,890	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,880	13	13,246		752	773	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,880	13	705		752	41	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,880	13	899		752	52	19
20	26	INSURANCE	ALLOCATED SQ FT	12,880	13	1,527		752	89	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,880	13	103,394		752	6,037	21
22	32	INTEREST	ALLOCATED SQ FT	12,880	13	89,152		752	5,205	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,880	13	81,334		752	4,749	23
24	19	PROFESSIONAL FEES (RE TAX	ALLOCATED SQ FT	12,880	13	11,747		752	686	24
25	TOTALS					\$ 2,490,426	\$ 1,625,498		\$ 133,876	25

Facility Name & ID Number Greenwood Care Ltd. # 0031971 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation			\$	\$			1
2	3	Housekeeping	Direct Allocation						14,075	2
3	4	Laundry	Direct Allocation						185	3
4	6	Repairs & Maintenance	Direct Allocation							4
5	10	Nursing	Direct Allocation						29,645	5
6	11	Activities	Direct Allocation							6
7	21	Office And Clerical	Direct Allocation							7
8	22	Employee Benefits	Direct Allocation							8
9	30	Fixed Assets-Depreciation	Direct Allocation							9
10	39	Ancillary	Direct Allocation							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					\$	\$		43,905	25

Facility Name & ID Number Greenwood Care Ltd. # 0031971 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation			\$	\$		\$ 159,564	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					\$	\$		\$ 159,564	25

Facility Name & ID Number Greenwood Care Ltd. # 0031971 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Greenwood Care Ltd. # 0031971 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Greenwood Care Ltd. # 0031971 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Greenwood Care Ltd. # 0031971 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

()

()

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

Facility Name & ID Number Greenwood Care Ltd. # 0031971 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

()

()

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	The Private Bank		X				\$	11,994,141			\$	580,945	1
2													2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	Lake Forest Bank		X	Line of Credit				725,000				14,205	6
7	SIR Management Allocation											(1,186)	7
8	See Supplemental Schedule												8
9	TOTAL Facility Related						\$	12,719,141			\$	593,964	9
	B. Non-Facility Related*												
10	Interest Income- Bldg Co.		X									(179)	10
11													11
12													12
13	See Supplemental Schedule												13
14	TOTAL Non-Facility Related						\$				\$	(179)	14
15	TOTALS (line 9+line14)						\$	12,719,141			\$	593,785	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 60,307 Line # 36

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

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

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

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	132,000	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.)				\$	183,399	2
3. Under or (over) accrual (line 2 minus line 1).				\$	51,399	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	188,000	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.)				\$	686	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 \$ 212 For 2001 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.				\$	240,085	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2006	121,402	8		
		2007	113,003	9		
		2008	117,342	10		
		2009	125,620	11		
		2010	178,650	12		
2011 Accrual = 178650 x 1.05 = \$188,000 (Rounded)						
Refund from 2001 does not effect Current Year's Tax Rate						
Allocation from SIR Management = \$4,749						

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$		16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

FACILITY NAME	<u>Greenwood Care Ltd.</u>	COUNTY	<u>Cook</u>
FACILITY IDPH LICENSE NUMBER	<u>0031971</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Steve Lavenda</u>		
TELEPHONE	<u>(847) 236-1111</u>	FAX #:	<u>(847) 236-1155</u>

Enter the tax index number and real estate tax assessed for 2010 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 2010.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>11-18-324-019-0000</u>	<u>Long-Term Care Property</u>	\$ <u>178,650.44</u>	\$ <u>178,650.44</u>
2. <u>See Attached</u>	<u>See Attached</u>	\$ <u>98,193.53</u>	\$ <u>4,489.86</u>
3. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u>276,843.97</u>	\$ <u>183,140.30</u>

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.)

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Greenwood Care Ltd.</u>	COUNTY	<u>Cook</u>
---------------	----------------------------	--------	-------------

FACILITY IDPH LICENSE NUMBER 0031971

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () FAX #: ()

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)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
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?

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.

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

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility - Greenwood Care LLC		1987	\$ 152,555	1
2					2
3	TOTALS			\$ 152,555	3

SEE ACCOUNTANTS' COMPILATION REPORT

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care Ltd.

0031971

Report Period Beginning:

01/01/11

Ending:

12/31/11

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)		1,507,265			74,830	74,830	191,251	67
68	Related Party Allocations (Pages 12H & 12I)		96,044	2,748		3,912	1,164	45,873	68
69	Financial Statement Depreciation			44,738			(44,738)		69
70	TOTAL (lines 4 thru 69)		\$ 5,048,869	\$ 208,142		\$ 273,269	\$ 65,127	\$ 2,827,355	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care Ltd.

0031971

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 5,048,869	\$ 208,142		\$ 273,269	\$ 65,127	\$ 2,827,355	1
2 Lighting	2008	4,653		20	233	233	892	2
3 Smoke Detectors	2008	3,732		20	187	187	715	3
4 Elevator Work	2008	8,954		20	448	448	1,380	4
5 Plumbing Repairs	2008	6,700		20	335	335	1,061	5
6 Elevator Repair	2008	5,000		20	250	250	917	6
7 Boiler Work	2009	4,839		20	242	242	726	7
8 Phone System	2009	10,392		20	520	520	1,516	8
9 Security Camera	2009	4,060		20	203	203	541	9
10 Mixing Valve	2009	5,711		20	286	286	642	10
11 Springler System Repair	2009	3,105		20	155	155	362	11
12 Replace Cylinders - Master Key System	2009	4,889		20	244	244	550	12
13 Boiler Work	2009	3,739		20	187	187	421	13
14 Windows	2010	11,568		20	145	145	145	14
15 Fire Rated Doors	2011	3,400		20	170	170	170	15
16 Windows: Rear Stairwell	2011	2,603		20	33	33	33	16
17 Sink Moved 2 Feet	2011	2,754		20	138	138	138	17
18 Test And Repair Fire Alarms	2011	2,507		20	125	125	125	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)		\$ 5,137,475	\$ 208,142		\$ 277,168	\$ 69,026	\$ 2,837,688	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,137,475	\$ 208,142		\$ 277,168	\$ 69,026	\$ 2,837,688	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)		\$ 5,137,475	\$ 208,142		\$ 277,168	\$ 69,026	\$ 2,837,688	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,137,475	\$ 208,142		\$ 277,168	\$ 69,026	\$ 2,837,688	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)		\$ 5,137,475	\$ 208,142		\$ 277,168	\$ 69,026	\$ 2,837,688	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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		\$ 5,137,475	\$ 208,142		\$ 277,168	\$ 69,026	\$ 2,837,688	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)		\$ 5,137,475	\$ 208,142		\$ 277,168	\$ 69,026	\$ 2,837,688	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care Ltd.

0031971

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Building Company Information								1
2 Buildings:								2
3								3
4								4
5								5
6								6
7								7
8 Leasehold Improvements:								8
9 Rear Freight Elevator	2008	141,600		20	7,080	7,080	28,320	9
10 Matthews Roofing - Masonry Work	2008	55,300		20	2,765	2,765	11,060	10
11 Flooring	2008	4,648		20	232	232	928	11
12 Nurses Stations - Cabinetry and Sinks	2008	29,158		20	1,458	1,458	5,832	12
13 Generator - Application/Permits, Engineering Cost	2009	16,844		30	561	561	1,683	13
14 Generator Cost and Installation	2009	189,600		30	6,320	6,320	18,960	14
15 Bathrooms - Valves, New Walls, Tiles, New Toilets, Sink	2009	42,000		20	2,100	2,100	6,300	15
16 Shower Room - Wall Work, Concrete, New Rubber Pan, Tiles	2009	4,375		20	219	219	657	16
17 Bathrooms - Valves, New Walls, Tiles, New Toilets, Sink	2009	52,500		20	2,625	2,625	7,875	17
18 Bathrooms - Valves, New Walls, Tiles, New Toilets, Sink	2009	94,500		20	4,725	4,725	14,175	18
19 Generator	2009	3,071		20	154	154	462	19
20 Bathrooms - Valves, New Walls, Tiles, New Toilets, Sink	2009	42,000		30	1,400	1,400	4,200	20
21 Bathrooms - Valves, New Walls, Tiles, New Toilets, Sink	2009	63,000		20	3,150	3,150	9,450	21
22 Bathrooms - Valves, New Walls, Tiles, New Toilets, Sink	2009	47,250		20	2,363	2,363	7,089	22
23 Roofing Work	2009	16,346		20	817	817	2,451	23
24								24
25 Boiler System	2010	72,862		20	3,643	3,643	7,286	25
26 Fl. 2 Shower Room - Wall Work, Concrete, Rubber Pan, Tiles	2010	6,700		10	670	670	1,340	26
27 First Floor -doors, wall work, replace ceiling tiles, carpet, tile	2010	140,819		20	7,041	7,041	14,082	27
28 Painting - First Floor	2010	27,225		20	1,361	1,361	2,723	28
29 Flooring - 2 and 3	2010	17,238		20	862	862	1,724	29
30 Lintel Work	2010	21,500		20	1,075	1,075	2,150	30
31 Resident Door Locks	2010	7,297		20	365	365	730	31
32 Electric - basement closet & lighting, utility room circuitry	2010	4,498		20	225	225	450	32
33 Kitchen Ceiling	2010	5,320		20	266	266	532	33
34								34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care Ltd.

0031971

Report Period Beginning:

01/01/11

Ending:

12/31/11

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 Information Continued		\$	\$		\$	\$	\$	1
2	FL 4 - Shower Room - Wall Work, Concrete, New Rubber Pan, Ti	2010	18,200		20	910	910	1,820	2
3	Wallpaper - First Floor & Conference Room	2010	8,175		20	409	409	818	3
4	FL1 Front, 2 Hallway Bath - ceiling, doors, hardware,toilet, sink, f	2010	15,503		20	775	775	1,550	4
5	Window Openings - Remodeling, Plaster, Drywall	2010	7,200		20	360	360	720	5
6	First Floor Remodeling - Wallpaper, Tiles	2010	9,512		20	476	476	951	6
7	Oxygen Room -replace vinyl flooring, duct work, install light, fan	2010	13,250		10	1,325	1,325	2,650	7
8	Elevator Panels	2010	2,900		10	290	290	580	8
9	Rooftop Fence/Coping	2010	11,690		20	585	585	1,169	9
10	Window Replacement	2010	81,115		20	4,056	4,056	8,112	10
11	Elevator Motor	2010	5,600		20	280	280	560	11
12	Fire Doors	2010	3,260		10	326	326	652	12
13	Replace antennae system with cable TV	2010	11,007		20	863	863	1,726	13
14	Fire Door	2010	2,650		10	265	265	530	14
15	Window Treatments	2010	29,426		10	2,943	2,943	5,885	15
16	Window Treatments	2010	3,103		10	310	310	621	16
17	Handrails	2010	22,860		20	1,143	1,143	2,286	17
18	Window Treatments - Dining Room	2010	4,611		10	461	461	922	18
19	Rail and Guards - Dining Room	2010	3,984		20	199	199	398	19
20	Condenser Fan/Outlet	2010	2,579		20	129	129	258	20
21	Steampipe Work - Water Leaks	2010	2,580		20	129	129	258	21
22	RegROUT Kitchen Floor	2010	2,862		20	143	143	286	22
23	Roof Repairs & Coating	2010	2,980		20	149	149	298	23
24	Wall Base Repairs	2010	6,267		20	313	313	627	24
25	Tuckpointing	2010	5,500		20	275	275	550	25
26	Parapet Repairs	2010	6,500		20	325	325	650	26
27	Grease Interceptor & Floor Drain	2011	7,400		20	370	370	370	27
28	Coffee Shop Custom Cabinet	2011	3,000		20	150	150	150	28
29	Painting of Entire Facility	2010	107,900		20	5,395	5,395	5,395	29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		\$ 1,507,265	\$		\$ 74,830	\$ 74,830	\$ 191,251	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care Ltd.

0031971

Report Period Beginning:

01/01/11

Ending:

12/31/11

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 Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	SIR Properties - SIR Management	1993	26,429	839	35	755	(84)	13,214	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	S.I.R. Management Inc.	1993	6,701	187	20	332	145	6,311	9
10	S.I.R. Management Inc.	1994	21		20			21	10
11	S.I.R. Management Inc.	1995	153		20	8	8	126	11
12	S.I.R. Management Inc.	1997	10,296	231	20	505	274	7,614	12
13	S.I.R. Management Inc.	1999	810		20	41	41	496	13
14	S.I.R. Management Inc.	1999	8,112		20			8,112	14
15	S.I.R. Management Inc.	2000	956		20	48	48	552	15
16	S.I.R. Management Inc.	2007	3,071	283	20	154	(129)	644	16
17	S.I.R. Management Inc.	2008	8,464	809	20	533	(276)	2,051	17
18	S.I.R. Management Inc.	2009	21,031	192	20	1,052	860	2,360	18
19	S.I.R. Management Inc.	2011	520	22	20	11	(11)	11	19
20									20
21	S.I.R. Properties - S.I.R. Management - Allocation	2010	1,595		20	80	80	106	21
22	S.I.R. Properties - S.I.R. Management - Allocation	2009	1,587	139	20	79	(60)	222	22
23	S.I.R. Properties - S.I.R. Management - Allocation	2007	463	38	20	23	(15)	116	23
24	S.I.R. Properties - S.I.R. Management - Allocation	2002	105		20	5	5	50	24
25	S.I.R. Properties - S.I.R. Management - Allocation	1999	3,349		20	167	167	2,093	25
26	S.I.R. Properties - S.I.R. Management - Allocation	1998	1,600		20	80	80	1,080	26
27	S.I.R. Properties - S.I.R. Management - Allocation	1997	100		20	5	5	77	27
28	S.I.R. Properties - S.I.R. Management - Allocation	1994	252	6	20	13	7	220	28
29	S.I.R. Properties - S.I.R. Management - Allocation	1993	429	2	20	21	19	397	29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		\$96,044	\$2,748		\$3,912	\$1,164	\$45,873	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 529,177	\$ 3,030	\$ 25,946	\$ 22,916	10	\$ 359,584	71
72	Current Year Purchases	263	7	7		10	7	72
73	Fully Depreciated Assets	204,222		13	13	10	204,222	73
74								74
75	TOTALS	\$ 733,662	\$ 3,037	\$ 25,966	\$ 22,929		\$ 563,813	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	\$	\$ 2,355	\$ 2,355	5	\$ 12,959	76
77		Allocated from SIR Management	2011	2,052	253	290	37	5	406	77
78										78
79										79
80	TOTALS			\$ 16,189	\$ 253	\$ 2,645	\$ 2,392		\$ 13,365	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,039,881	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 211,432	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 305,779	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 94,347	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,414,867	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

**

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

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☒ NO
16. Rental Amount for movable equipment: \$11,029
- Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.

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

☒ 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

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

		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)	\$			

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

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

12345678										
	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	N/A	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
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 40,562	\$ 47,037	1
2	Cash-Patient Deposits	35,884	35,884	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,080,558	1,080,558	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,511	30,099	6
7	Other Prepaid Expenses	4,842	4,842	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	24,236	217,109	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,215,593	\$ 1,415,529	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	1,010,822	2,293,505	15
16	Equipment, at Historical Cost	957,229	1,402,755	16
17	Accumulated Depreciation (book methods)	(1,203,283)	(3,073,527)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	47,809	180,472	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 812,577	\$ 3,229,822	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,028,170	\$ 4,645,351	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 94,501	\$ 94,501	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	35,901	35,901	28
29	Short-Term Notes Payable	725,000	725,000	29
30	Accrued Salaries Payable	232,589	232,589	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,376	8,376	31
32	Accrued Real Estate Taxes(Sch.IX-B)		188,000	32
33	Accrued Interest Payable		47,977	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	58,009	82,245	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,154,376	\$ 1,414,589	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,994,141	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 11,994,141	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,154,376	\$ 13,408,730	46
47	TOTAL EQUITY(page 18, line 24)	\$ 873,794	\$ (8,763,379)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,028,170	\$ 4,645,351	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 814,205	1
2	Restatements (describe):		2
3	<u>Rounding</u>	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 814,204	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	59,590	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 59,590	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)	\$ 873,794	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,506,098	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,506,098	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,481	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,481	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,507,579	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,014,539	31
32	Health Care	1,741,886	32
33	General Administration	1,521,082	33
	B. Capital Expense		
34	Ownership	1,091,094	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	79,388	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,447,989	40
41	Income before Income Taxes (line 30 minus line 40)**	59,590	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 59,590	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,992	2,097	\$ 72,119	\$ 34.39	1
2	Assistant Director of Nursing	1,989	2,094	56,238	26.86	2
3	Registered Nurses					3
4	Licensed Practical Nurses	14,735	15,510	398,146	25.67	4
5	CNAs & Orderlies	49,236	51,828	604,349	11.66	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,991	2,096	31,141	14.86	9
10	Activity Assistants	14,158	14,903	144,556	9.70	10
11	Social Service Workers	15,321	16,127	232,068	14.39	11
12	Dietician	1,990	2,095	35,589	16.99	12
13	Food Service Supervisor					13
14	Head Cook	5,513	6,001	56,300	9.38	14
15	Cook Helpers/Assistants	9,651	10,159	92,349	9.09	15
16	Dishwashers					16
17	Maintenance Workers	3,973	4,183	49,730	11.89	17
18	Housekeepers	18,607	19,587	199,587	10.19	18
19	Laundry					19
20	Administrator	1,893	2,086	81,763	39.20	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,521	14,233	166,361	11.69	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	2,276	2,396	27,795	11.60	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	4,444	4,444	18,330	4.12	33
34	TOTAL (lines 1 - 33)	161,290	169,839	\$ 2,266,421 *	\$ 13.34	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 9,504	01-03	35
36	Medical Director	Monthly	7,800	09-03	36
37	Medical Records Consultant	Monthly	4,512	10-03	37
38	Nurse Consultant	Monthly	34,800	10-03	38
39	Pharmacist Consultant	Monthly	9,135	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	3,738	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Dir. Of Food Services	Monthly	17,400	01-03	47
48	Specialized Rehab	Monthly	17,400	10A-03	48
49	TOTAL (lines 35 - 48)		\$ 104,289		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	1,143	40,014	10-03	51
52	Certified Nurse Assistants/Aides	18	270	10-03	52
53	TOTAL (lines 50 - 52)	1,161	\$ 40,284		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount	
Delvin Rychener	Administrator		\$ 81,763	Workers' Compensation Insurance		\$ 37,544	IDPH License Fee	\$ 992	
				Unemployment Compensation Insurance		23,324	Advertising: Employee Recruitment	502	
				FICA Taxes		165,821	Health Care Worker Background Check	6,272	
				Employee Health Insurance		159,984	(Indicate # of checks performed 33)		
				Employee Meals		18,524	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*			Licenses & Permits	10,079	
				Union Pension Plan		21,377	Dues & Subscriptions	288	
				401K Matching Contributions		5,100	Advertising & Promotion	3,572	
				Other Employee Benefits		3,285	Allocation from SIR Management	850	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)							Less: Public Relations Expense	()	
							Non-allowable advertising	(3,572)	
							Yellow page advertising	()	
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 434,959			\$ 18,983		
Description				Amount					
SIR Management - Consulting Fees				\$ 382,330					
SIR Management - Director of Administrative Services				34,800					
SIR Management - Ancillary Management Charges				34,800					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 451,930					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
SIR Management	Accounting		\$ 36,000			\$	Out-of-State Travel	\$	
SIR Management	Dir of Regulatory Services		17,400						
SIR Management	Bookkeeping Fees		64,380						
See Attached	Legal Fees		7,135				In-State Travel		
Personnel Planners	Unemployment Tax Consult.		1,660						
Pinacle Consulting	Customer Satisfaction Program		2,589						
LTC Solutions	MDS Software		1,500						
Frost, Ruttenberg, & Rothblatt	Accounting		15,158				Seminar Expense	2,530	
							Allocation from SIR Management	507	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL			(agree to Sch. V, line 24, col. 8)		
				\$			TOTAL		
\$ 145,822							\$ 3,037		

*** Attach copy of IMRF notifications**
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 \$11,310
- (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.

\$15,003

Line

10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A
- (9) Are you presently operating under a sublease agreement?

YES

X

NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$79,388

This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$18,524

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 out of Schedule V?

N/A
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

N/A

Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT