

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: 0031971 Facility Name: Greenwood Care Ltd. Address: 1406 N. Chicago Ave. Evanston 60201 County: Cook Telephone Number: (847) 328-7508 Fax #: (847) 869-4878 HFS ID Number: Date of Initial License for Current Owners: 01/01/90 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation X "Sub-S" Corp. Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: Steve Lavenda Telephone Number: (847) 236-1111 Email Address:	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/12 to 12/31/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. Officer or Administrator of Provider (Signed) (Type or Print Name) (Title) (Signed) (Date) Paid Preparer (Print Name and Title) Cary Drazner, C.P.A. (Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015 (Telephone) (847) 236-1111 Fax #: (847) 236-1155 MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care Ltd.

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

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	53,070	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	145	TOTALS	145	53,070	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	48,230	752		48,982	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,230	752		48,982	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.30%

D. How many bed-hold days during this year were paid by the Department? 823 (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 2/01/1987

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 2/01/1987 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: 12/31/12 Fiscal Year: 12/31/12

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

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

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	187,593	20,409	27,111	235,113		235,113	(12,245)	222,868			1
2	Food Purchase		239,978		239,978	(19,087)	220,891	(37)	220,854			2
3	Housekeeping	199,574	27,420		226,994		226,994		226,994			3
4	Laundry		14,065	11,598	25,663		25,663		25,663			4
5	Heat and Other Utilities			104,428	104,428		104,428	(3,693)	100,735			5
6	Maintenance	51,908	54,946	134,758	241,612		241,612	2,797	244,409			6
7	Other (specify):*							6,588	6,588			7
8	TOTAL General Services	439,075	356,818	277,895	1,073,788	(19,087)	1,054,701	(6,590)	1,048,111			8
	B. Health Care and Programs											
9	Medical Director			7,500	7,500		7,500		7,500			9
10	Nursing and Medical Records	1,130,779	40,771	81,815	1,253,365		1,253,365	(17,670)	1,235,695			10
10a	Therapy	47,500		17,400	64,900		64,900	(9,028)	55,872			10a
11	Activities	176,759	15,176	2,244	194,179		194,179		194,179			11
12	Social Services	220,010			220,010		220,010		220,010			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							4,261	4,261			15
16	TOTAL Health Care and Programs	1,575,048	55,947	108,959	1,739,954		1,739,954	(22,437)	1,717,517			16
	C. General Administration											
17	Administrative	85,486		419,301	504,787		504,787	(342,021)	162,766			17
18	Directors Fees											18
19	Professional Services			152,654	152,654	(8,389)	144,265	(101,183)	43,082			19
20	Dues, Fees, Subscriptions & Promotions			41,965	41,965		41,965	(25,538)	16,427			20
21	Clerical & General Office Expenses	189,114	27,996	73,545	290,655		290,655	67,436	358,091			21
22	Employee Benefits & Payroll Taxes			458,529	458,529	19,087	477,616		477,616			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,100	2,100		2,100	965	3,065			24
25	Other Admin. Staff Transportation			4,118	4,118		4,118	7,071	11,189			25
26	Insurance-Prop.Liab.Malpractice			96,562	96,562		96,562	8,967	105,529			26
27	Other (specify):*							34,689	34,689			27
28	TOTAL General Administration	274,600	27,996	1,248,774	1,551,370	10,698	1,562,068	(349,614)	1,212,454			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,288,723	440,761	1,635,628	4,365,112	(8,389)	4,356,723	(378,641)	3,978,082			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			42,956	42,956		42,956	266,376	309,332			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			28,534	28,534		28,534	555,040	583,574			32
33	Real Estate Taxes					8,389	8,389	184,154	192,543			33
34	Rent-Facility & Grounds			1,074,000	1,074,000		1,074,000	(1,074,000)				34
35	Rent-Equipment & Vehicles			6,291	6,291		6,291	4,511	10,802			35
36	Other (specify):*							59,561	59,561			36
37	TOTAL Ownership			1,151,781	1,151,781	8,389	1,160,170	(4,358)	1,155,812			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			375,126	375,126		375,126		375,126			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			375,126	375,126		375,126		375,126			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,288,723	440,761	3,162,535	5,892,019		5,892,019	(382,998)	5,509,021			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(5,436)	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	96,535	30		9
10	Interest and Other Investment Income	(15,685)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(37)	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	(10,450)	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	(5,054)	21		24
25	Fund Raising, Advertising and Promotional	(2,312)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(800)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(55,827)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 935		\$	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)	(383,933)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (383,933)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (382,998)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

ID#

0031971

Report Period Beginning:

01/01/12

Ending:

12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Fees	\$ (6,889)	21	1
2	Theft & Damage	(1,236)	21	2
3	Non-Allowable Legal	(7,040)	19	3
4	Non Allowable Collections	(933)	21	4
5				5
6	Alliance for Living - PAC Dues	(13,120)	20	6
7	Additional Seminar	495	24	7
8				8
9	Building Company:			9
10	Amortization	(4,041)	36	10
11	Office Expense	(10)	21	11
12	Professional Fees	(7,725)	19	12
13	Filing Fees	(250)	21	13
14	Capitalized R&M	(15,714)	06	14
15	additional R&M	1,103	06	15
16	Non Allowable Professional Fees	(433)	19	16
17	Misc. Income	(34)	21	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	(55,827)		49

ID#

0031971

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

Summary A

12/31/12

[illegible]

Summary B

12/31/12

[illegible]

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	\$ 1,074,000	Greenwood Care, LLC	100.00%	\$	\$ (1,074,000)	1
2	V	32	Interest Income	58	Greenwood Care, LLC	100.00%		(58)	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%	163,187	163,187	4
5	V	21	Filing Fees		Greenwood Care, LLC	100.00%	250	250	5
6	V	32	Mortgage Interest		Greenwood Care, LLC	100.00%	571,782	571,782	6
7	V	36	Mortgage Insurance		Greenwood Care, LLC	100.00%	59,561	59,561	7
8	V	19	Professional Fees		Greenwood Care, LLC	100.00%	7,725	7,725	8
9	V	21	Office Expense		Greenwood Care, LLC	100.00%	10	10	9
10	V	26	Property Insurance		Greenwood Care, LLC	100.00%	7,799	7,799	10
11	V	33	RE Tax Expense		Greenwood Care, LLC	100.00%	181,522	181,522	11
12	V	06	R&M		Greenwood Care, LLC	100.00%	26,171	26,171	12
13	V								13
14	Total			\$ 1,074,058			\$ 1,022,048	\$ * (52,010)	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.

☒ 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%	\$ 6,373	\$ (11,027)	15
16	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	499	499	16
17	V	10	NURSING	34,800	S.I.R. MANAGEMENT, INC.	100.00%	11,432	(23,368)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	1,923	1,923	18
19	V	19	PROFESSIONAL FEES	114,300	S.I.R. MANAGEMENT, INC.	100.00%	9,337	(104,963)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	344	344	20
21	V	21	CLERICAL & GENERAL	34,800	S.I.R. MANAGEMENT, INC.	100.00%	43,602	8,802	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	470	470	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	7,071	7,071	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,076	1,076	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	7,715	7,715	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(5,914)	(5,914)	26
27	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	4,511	4,511	27
28	V								28
29	V	17	ADMINISTRATIVE	419,301	S.I.R. MANAGEMENT, INC.	100.00%	19,478	(399,823)	29
30	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	161	161	30
31	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	73,527	73,527	31
32	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	14,370	14,370	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 620,601			\$ 195,975	\$ * (424,626)	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 SALARIES	\$ 17,400	S.I.R. MANAGEMENT, INC.	100.00%	\$ 5,155	\$ (12,245)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	874	874	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	5,698	5,698	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	959	959	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	57,802	57,802	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	11,051	11,051	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	12,604	12,604	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	17,400	S.I.R. MANAGEMENT, INC.	100.00%	8,372	(9,028)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,379	1,379	25
26	V								26
27	V	6	MAINTENANCE SALARIES	26,818	S.I.R. MANAGEMENT, INC.	100.00%	28,677	1,859	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	5,215	5,215	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	1,743	1,743	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	405	405	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%	53	53	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	92	92	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	6,654	6,654	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	4,915	4,915	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	2,632	2,632	37
38	V								38
39	Total			\$ 61,618			\$ 154,321	\$ * 92,703	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	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 110,404	\$ 110,404	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	110,404	CCS Employee Benefits Group	100.00%		(110,404)	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			\$ 110,404			\$ 110,404	\$ *	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 (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

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%	APPLEWOOD REHABILITATION CENTER,LLC	MATTESON	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	2
3	DENNIS TOSSI	2.758%	BRYN MAWR CARE INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	ERIC ROTHNER	51.727%	COLUMBUS PARK NURSING & REHABILITATION CENTER, INC.	CHICAGO	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	4
5	JULIANA R. BARRISH TRUST DTD 1/26/93	15.517%	DECATUR MANOR HEALTHCARE,LLC	DECATUR				5
6	LOUISE BERGTHOLD	3.448%	ELMWOOD CARE, INC.	ELMWOOD PARK				6
7	MICHAEL R. GIANNINI TRUST DTD	3.448%	FAIRVIEW NURSING PLAZA, INC.	ROCKFORD				7
8	THOMAS WINTER	4.137%	MAPLEWOOD CARE, INC.	ELGIN				8
9			NEIGHBORS REHABILITATION CENTER,LLC	BYRON				9
10			REGENCY REHABILITATION CENTER,LLC	NILES				10
11			ROCK ISLAND NURSING & REHAB CENTER,LLC	ROCK ISLAND				11
12			WILSON CARE, INC.	CHICAGO				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

VII. RELATED PARTIES

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

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

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

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	Relative	Administrative	0.00%	See Attached	2.01	5.03%	Alloc. Salary	\$ 9,647	17-7	1
2	Bryan Barrish	Relative	Administrative	0.00%	See Attached	2.3	5.11%	Alloc. Salary	11,485	17-7	2
3	Kirsten Barrish	Relative	Clerical	0.00%	See Attached	2.3	5.75%	Alloc. Salary	2,676	21-7	3
4	Sarah Barrish	Relative	Administrative	0.00%	See Attached	2.87	5.74%	Alloc. Salary	6,945	17-7	4
5	Nenita Guzman	Relative	Dietary	0.00%	See Attached	2.87	5.74%	Alloc. Salary	5,155	1-7	5
6	Louise Bergthold	Owner	Administrative	3.45%	See Attached	3.45	5.75%	Alloc. Salary	11,485	17-7	6
7	Tom Winter	Owner	Administrative	4.14%	See Attached	3.45	5.75%	Alloc. Salary	11,485	17-7	7
8	Adam Vales	Relative	Clerical	0.00%	See Attached	0.73	1.83%	Alloc. Salary	1,340	22-7	8
9	David Winter	Relative	Clerical	0.00%	See Attached	0.37	5.69%	Alloc. Salary	194	21-7	9
10	Matthew Winter	Relative	Clerical	0.00%	See Attached	0.09	5.63%	Alloc. Salary	50	21-7	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	\$ 60,462		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: 01/01/12 Ending: 12/31/12

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

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	852,976	13	\$ 110,978	\$ 47,841	48,982	\$ 6,373	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	852,976	13	8,688		48,982	499	2
3	10	NURSING	PATIENT DAYS	852,976	13	199,072	199,072	48,982	11,432	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	852,976	13	33,485		48,982	1,923	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	852,976	13	162,603	94,013	48,982	9,337	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	852,976	13	5,990		48,982	344	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	852,976	13	759,296	684,975	48,982	43,602	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	852,976	13	8,182		48,982	470	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	852,976	13	123,128		48,982	7,071	9
10	26	INSURANCE	PATIENT DAYS	852,976	13	18,740		48,982	1,076	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	852,976	13	134,350		48,982	7,715	11
12	32	INTEREST	PATIENT DAYS	852,976	13	(102,988)		48,982	(5,914)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	852,976	13	78,558		48,982	4,511	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	852,976	13	339,187	339,187	48,982	19,478	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	852,976	13	2,801		48,982	161	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	852,976	13	1,280,400	1,178,532	48,982	73,527	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	852,976	13	250,244		48,982	14,370	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,412,714	\$ 2,543,620		\$ 195,975	25

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

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	1	DIETARY SALARIES	PATIENT DAYS	852,976	13	\$ 89,778	\$ 89,778	48,982	\$ 5,155	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	852,976	13	15,225		48,982	874	2
3	10	NURSING SALARIES	PATIENT DAYS	852,976	13	99,226	99,226	48,982	5,698	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	852,976	13	16,696		48,982	959	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	852,976	13	1,006,570	1,006,570	48,982	57,802	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	852,976	13	192,450		48,982	11,051	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	852,976	13	219,485		48,982	12,604	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	288,024	13	138,589	138,589	17,400	8,372	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	288,024	13	22,823		17,400	1,379	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	401,695	13	429,544	429,544	26,818	28,677	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	401,695	13	78,117		26,818	5,215	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	13	30,330		740	1,743	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	13	7,048		740	405	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	13	717		740	41	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	13	925		740	53	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	13	1,601		740	92	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	13	115,812		740	6,654	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	13	85,544		740	4,915	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	13	45,809		740	2,632	23
24										24
25	TOTALS					\$ 2,596,289	\$ 1,763,707		\$ 154,321	25

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

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		\$	\$		\$ 110,404	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				\$	\$		\$ 110,404	25

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

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

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

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

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

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

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				\$	11,841,627			\$	571,782	1
2													2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	Lake Forest Bank		X	Line of Credit				600,000				28,534	6
7	SIR Management Allocation		X									4,915	7
8	See Supplemental Schedule												8
9	TOTAL Facility Related						\$	12,441,627			\$	605,231	9
	B. Non-Facility Related*												
10	Interest Income		X									(15,685)	10
11	Interest Income- Bldg Co.		X									(58)	11
12	Allocated from SIR Management		X									(5,914)	12
13	See Supplemental Schedule												13
14	TOTAL Non-Facility Related						\$				\$	(21,657)	14
15	TOTALS (line 9+line14)						\$	12,441,627			\$	583,574	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 59,561 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.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.			\$	188,000	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.)			\$	182,154	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(5,846)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	190,000	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.)			\$	8,389	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 \$ <u>24,643</u> For <u>02;09</u> 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.			\$	192,543	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	<u>113,003</u>	8	
		2008	<u>117,342</u>	9	
		2009	<u>125,620</u>	10	
		2010	<u>178,650</u>	11	
		2011	<u>179,522</u>	12	
2012 Accrual = \$179,522 x 1.05 = \$190,000 (Rounded)					
Refunds from 2002 and 2009 do not effect Current Year's Tax Rate					
Allocation from SIR Management = \$2,632					

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$		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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Greenwood Care Ltd. COUNTY Cook

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 2011 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 2011.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. <u>11-18-324-019-0000</u>	<u>Long-Term Care Property</u>	\$ <u>179,522.00</u>	\$ <u>179,522.00</u>
2. <u>See Attached</u>	<u>See Attached</u>	\$ <u>101,165.17</u>	\$ <u>4,552.28</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>280,687.17</u></u>	\$ <u><u>184,074.28</u></u>

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

IMPORTANT NOTICE

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

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

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

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

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Greenwood Care Ltd. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0031971

CONTACT PERSON REGARDING THIS REPORT

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</u> <u>Applicable to</u> <u>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? YES NO

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

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

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

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	145		1987	1969	\$ 1,845,500	\$ 72,192	35	\$ 113,703	\$ 41,511	\$ 1,816,587	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1984		2,672		20	76	76	2,031	9
10	Various		1987		24,869		20	694	694	19,122	10
11	Various		1988		27,733		20	321	321	19,677	11
12	Various		1989		7,668		20	87	87	5,593	12
13	Various		1990		9,800		20			9,235	13
14	Various		1992		25,025		20	559	559	24,913	14
15	Various		1993		63,911		20	2,866	2,866	62,734	15
16	Various		1994		20,319		20	1,016	1,016	18,683	16
17	Various		1995		73,839		20	3,692	3,692	64,951	17
18	Various		1996		109,220		20	5,461	5,461	90,387	18
19	Various		1997		73,171		20	3,659	3,659	56,729	19
20	Various		1998		58,371		20	2,919	2,919	42,257	20
21	Various		1999		179,834		20	9,098	9,098	122,931	21
22	Various		2000		171,876		20	8,594	8,594	109,215	22
23	Various		2001		43,730		20	2,187	2,187	25,904	23
24	Various		2002		87,606		20	3,849	3,849	54,445	24
25	Various		2003		59,109		20	4,204	4,204	38,897	25
26	Various		2004		77,107		20	4,569	4,569	39,486	26
27	Various		2005		58,861		20	3,273	3,273	24,330	27
28	Various		2006		271,462		20	13,573	13,573	88,872	28
29	Various		2007		153,877		20	8,049	8,049	45,700	29
30	Various		2008		29,039		20	1,452	1,452	6,417	30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

Facility Name & ID Number Greenwood Care Ltd.

0031971

Report Period Beginning:

01/01/12

Ending:

12/31/12

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)		1,522,979	62,443		75,617	13,174	272,263	67
68	Related Party Allocations (Pages 12H & 12I)		112,242	3,503		4,302	799	51,084	68
69	Financial Statement Depreciation			42,956			(42,956)		69
70	TOTAL (lines 4 thru 69)		\$ 5,109,820	\$ 181,094		\$ 273,819	\$ 92,725	\$ 3,112,443	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:

01/01/12

Ending:

12/31/12

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		\$ 5,109,820	\$ 181,094		\$ 273,819	\$ 92,725	\$ 3,112,443	1
2 Boiler Work	2009	4,839		20	242	242	968	2
3 Phone System	2009	10,392		20	520	520	2,035	3
4 Security Camera	2009	4,060		20	203	203	744	4
5 Mixing Valve	2009	5,711		20	286	286	928	5
6 Springler System Repair	2009	3,105		20	155	155	518	6
7 Replace Cylinders - Master Key System	2009	4,889		20	244	244	794	7
8 Boiler Work	2009	3,739		20	187	187	608	8
9 Windows	2010	11,568		20	1,157	1,157	2,410	9
10 Fire Rated Doors	2011	3,400		20	170	170	340	10
11 Windows: Rear Stairwell	2011	2,603		20	130	130	163	11
12 Sink Moved 2 Feet	2011	2,754		20	138	138	276	12
13 Test And Repair Fire Alarms	2011	2,507		20	125	125	250	13
14 Electric Wiring	2012	22,000		20	1,100	1,100	1,100	14
15 Elevator Recall System	2012	14,490		20	483	483	483	15
16 5Th Flr Shower-New Floor & Wall Tile,New Drywall, Fixtures	2012	10,400		20	347	347	347	16
17 Stairwell Railing	2012	6,580		20	55	55	55	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)		\$ 5,222,857	\$ 181,094		\$ 279,360	\$ 98,266	\$ 3,124,461	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 12B, Carried Forward		\$ 5,222,857	\$ 181,094		\$ 279,360	\$ 98,266	\$ 3,124,461	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)		\$ 5,222,857	\$ 181,094		\$ 279,360	\$ 98,266	\$ 3,124,461	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		\$ 5,222,857	\$ 181,094		\$ 279,360	\$ 98,266	\$ 3,124,461	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)		\$ 5,222,857	\$ 181,094		\$ 279,360	\$ 98,266	\$ 3,124,461	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 12D, Carried Forward	\$ 5,222,857	\$ 181,094		\$ 279,360	\$ 98,266	\$ 3,124,461	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)	\$ 5,222,857	\$ 181,094		\$ 279,360	\$ 98,266	\$ 3,124,461	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:

01/01/12

Ending:

12/31/12

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	7,080	20	7,080		35,400	9
10 Matthews Roofing - Masonry Work	2008	55,300	2,765	20	2,765		13,825	10
11 Flooring	2008	4,648	232	20	232		1,160	11
12 Nurses Stations - Cabinetry and Sinks	2008	29,158		20	1,458	1,458	7,290	12
13 Generator - Application/Permits, Engineering Cost	2009	16,844		30	561	561	2,244	13
14 Generator Cost and Installation	2009	189,600		30	6,320	6,320	25,280	14
15 Bathrooms - Valves, New Walls, Tiles, New Toilets, Sink	2009	42,000		20	2,100	2,100	8,400	15
16 Shower Room - Wall Work, Concrete, New Rubber Pan, Tiles	2009	4,375	219	20	219		876	16
17 Bathrooms - Valves, New Walls, Tiles, New Toilets, Sink	2009	52,500		20	2,625	2,625	10,500	17
18 Bathrooms - Valves, New Walls, Tiles, New Toilets, Sink	2009	94,500		20	4,725	4,725	18,900	18
19 Generator	2009	3,071		20	154	154	616	19
20 Bathrooms - Valves, New Walls, Tiles, New Toilets, Sink	2009	42,000		30	1,400	1,400	5,600	20
21 Bathrooms - Valves, New Walls, Tiles, New Toilets, Sink	2009	63,000		20	3,150	3,150	12,600	21
22 Bathrooms - Valves, New Walls, Tiles, New Toilets, Sink	2009	47,250		20	2,363	2,363	9,452	22
23 Roofing Work	2009	16,346	817	20	817		3,268	23
24								24
25 Boiler System	2010	72,862	3,643	20	3,643		10,929	25
26 Fl. 2 Shower Room - Wall Work, Concrete, Rubber Pan, Tiles	2010	6,700	670	10	670		2,010	26
27 First Floor -doors, wall work, replace ceiling tiles, carpet, tile	2010	140,819	7,041	20	7,041		21,123	27
28 Painting - First Floor	2010	27,225	1,361	20	1,361		4,083	28
29 Flooring - 2 and 3	2010	17,238	862	20	862		2,586	29
30 Lintel Work	2010	21,500	1,075	20	1,075		3,225	30
31 Resident Door Locks	2010	7,297	365	20	365		1,095	31
32 Electric - basement closet & lighting, utility room circuitry	2010	4,498	225	20	225		675	32
33 Kitchen Ceiling	2010	5,320	266	20	266		798	33
34 Additional Depreciation			26,061					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:

01/01/12

Ending:

12/31/12

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	910	20	910		2,730	2
3	Wallpaper - First Floor & Conference Room	2010	8,175		20	409	409	1,227	3
4	FL1 Front, 2 Hallway Bath - ceiling, doors, hardware,toilet, sink, f	2010	15,503	775	20	775		2,325	4
5	Window Openings - Remodeling, Plaster, Drywall	2010	7,200	360	20	360		1,080	5
6	First Floor Remodeling - Wallpaper, Tiles	2010	9,512	476	20	476		1,428	6
7	Oxygen Room -replace vinyl flooring, duct work, install light, fan	2010	13,250	1,325	10	1,325		3,975	7
8	Elevator Panels	2010	2,900		10	290	290	870	8
9	Rooftop Fence/Coping	2010	11,690		20	585	585	1,755	9
10	Window Replacement	2010	81,115		20	4,056	4,056	12,168	10
11	Elevator Motor	2010	5,600		20	280	280	840	11
12	Fire Doors	2010	3,260		10	326	326	978	12
13	Replace antennae system with cable TV	2010	11,007		20	863	863	2,589	13
14	Fire Door	2010	2,650		10	265	265	795	14
15	Window Treatments	2010	29,426		10	2,943	2,943	8,829	15
16	Window Treatments	2010	3,103		10	310	310	930	16
17	Handrails	2010	22,860		20	1,143	1,143	3,429	17
18	Window Treatments - Dining Room	2010	4,611		10	461	461	1,383	18
19	Rail and Guards - Dining Room	2010	3,984		20	199	199	597	19
20	Condenser Fan/Outlet	2010	2,579		20	129	129	387	20
21	Steampipe Work - Water Leaks	2010	2,580		20	129	129	387	21
22	RegROUT Kitchen Floor	2010	2,862		20	143	143	429	22
23	Roof Repairs & Coating	2010	2,980		20	149	149	447	23
24	Wall Base Repairs	2010	6,267		20	313	313	939	24
25	Tuckpointing	2010	5,500		20	275	275	825	25
26	Parapet Repairs	2010	6,500		20	325	325	975	26
27	Grease Interceptor & Floor Drain	2011	7,400	370	20	370		740	27
28	Coffee Shop Custom Cabinet	2011	3,000	150	20	150		300	28
29	Painting of Entire Facility	2010	107,900	5,395	20	5,395		16,185	29
30	Duct extenstions-community bathrooms	2012	5,321		20	266	266	266	30
31	Sprinkler System Repair	2012	3,367		20	168	168	168	31
32	Boiler Repair	2012	3,326		20	166	166	166	32
33	Kitchen-patch walls and paint	2012	3,700		20	185	185	185	33
34	TOTAL (12F & 12G lines 1 thru 33)		\$ 1,522,979	\$ 62,443		\$ 75,617	\$ 39,235	\$ 272,263	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:

01/01/12

Ending:

12/31/12

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	<u>SIR Properties - SIR Management</u>	2009	14,364		35	368	368	1,120	3
4	<u>SIR Properties - SIR Management</u>	1993	26,009	826	35	743	(83)	14,491	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	<u>Alloc. - S.I.R. Management</u>	1993	6,594	184	20	327	143	6,538	9
10	<u>Alloc. - S.I.R. Management</u>	1994	21		20			21	10
11	<u>Alloc. - S.I.R. Management</u>	1995	151		20	8	8	131	11
12	<u>Alloc. - S.I.R. Management</u>	1997	10,132	227	20	497	270	7,990	12
13	<u>Alloc. - S.I.R. Management</u>	1999	797		20	40	40	528	13
14	<u>Alloc. - S.I.R. Management</u>	1999	8,112		20			8,112	14
15	<u>Alloc. - S.I.R. Management</u>	2000	941		20	47	47	590	15
16	<u>Alloc. - S.I.R. Management</u>	2007	3,022	206	20	151	(55)	785	16
17	<u>Alloc. - S.I.R. Management</u>	2008	8,329	796	20	525	(271)	2,543	17
18	<u>Alloc. - S.I.R. Management</u>	2009	20,697	189	20	1,035	846	3,358	18
19	<u>Alloc. - S.I.R. Management</u>	2011	512	51	20	51		73	19
20	<u>Alloc. - S.I.R. Management</u>	2012	1,639	34	20	34		34	20
21									21
22	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	2012	1,593	848	20	10	(838)	10	22
23	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	2010	1,570		20	78	78	183	23
24	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	2009	1,562	98	20	78	(20)	297	24
25	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	2007	455	36	20	23	(13)	137	25
26	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	2002	103		20	5	5	54	26
27	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	1999	3,296		20	165	165	2,225	27
28	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	1998	1,575		20	79	79	1,142	28
29	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	1997	98		20	5	5	81	29
30	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	1994	248	6	20	12	6	229	30
31	<u>Alloc. - S.I.R. Properties - S.I.R. Management</u>	1993	422	2	20	21	19	412	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)		\$112,242	\$3,503		\$4,302	\$799	\$51,084	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	\$526,499	\$29,245	\$25,617	\$(3,628)	10	\$368,794	71
72	Current Year Purchases	61,172	2,172	2,872	700	10	2,872	72
73	Fully Depreciated Assets	206,046				10	206,046	73
74								74
75	TOTALS	\$793,717	\$31,417	\$28,488	\$(2,929)		\$577,712	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	\$	\$1,178	\$1,178	5	\$14,137	76
77		Allocated from SIR Management	2011	2,020	286	306	20	5	706	77
78										78
79										79
80	TOTALS			\$16,157	\$286	\$1,484	\$1,198		\$14,843	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)	\$6,185,286
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$212,797
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$309,332
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$96,535
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,717,015

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

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

**

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

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

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$ 10,802
- 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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	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
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental									13
14	TOTAL			\$		\$	\$		\$	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 14,662	\$ 30,826	1
2	Cash-Patient Deposits	37,624	37,624	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,075,161	1,075,161	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,511	30,167	6
7	Other Prepaid Expenses	2,933	2,933	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule		219,762	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,159,891	\$ 1,396,473	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	1,064,492	2,347,175	15
16	Equipment, at Historical Cost	995,270	1,463,419	16
17	Accumulated Depreciation (book methods)	(1,246,239)	(3,279,670)	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	56,225	184,847	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 869,748	\$ 3,142,388	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,029,639	\$ 4,538,861	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 109,098	\$ 124,489	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	37,624	37,624	28
29	Short-Term Notes Payable	600,000	600,000	29
30	Accrued Salaries Payable	237,882	237,882	30
31	Accrued Taxes Payable (excluding real estate taxes)	32,742	32,742	31
32	Accrued Real Estate Taxes(Sch.IX-B)		190,000	32
33	Accrued Interest Payable		47,367	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	154,933	154,933	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,172,279	\$ 1,425,037	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,841,627	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)	\$	\$ 11,841,627	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,172,279	\$ 13,266,664	46
47	TOTAL EQUITY(page 18, line 24)	\$ 857,360	\$ (8,727,803)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,029,639	\$ 4,538,861	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 873,794	1
2	Restatements (describe):		2
3	Rounding	(2)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 873,792	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	34,318	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	(50,750)	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)	\$ (16,432)	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)	\$ 857,360	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			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,884,775	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,884,775	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	15,685	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 15,685	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	25,877	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 25,877	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,926,337	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,073,788	31
32	Health Care	1,739,954	32
33	General Administration	1,551,370	33
	B. Capital Expense		
34	Ownership	1,151,781	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	375,126	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,892,019	40
41	Income before Income Taxes (line 30 minus line 40)**	34,318	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 34,318	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 5,696,686	44
45	Private Pay - Net Inpatient Revenue	86,852	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Prior Period Revenues	101,237	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,884,775	49

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.
*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,011	2,230	\$ 86,059	\$ 38.59	1
2	Assistant Director of Nursing	1,897	2,091	58,089	27.78	2
3	Registered Nurses	1,404	1,421	36,610	25.76	3
4	Licensed Practical Nurses	13,240	14,003	371,147	26.50	4
5	CNAs & Orderlies	44,195	48,956	550,802	11.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,391	3,507	47,500	13.54	8
9	Activity Director	1,947	2,091	32,349	15.47	9
10	Activity Assistants	13,688	14,648	144,410	9.86	10
11	Social Service Workers	13,518	15,066	220,010	14.60	11
12	Dietician	1,900	2,147	37,937	17.67	12
13	Food Service Supervisor					13
14	Head Cook	4,821	5,330	50,593	9.49	14
15	Cook Helpers/Assistants	10,222	10,625	99,063	9.32	15
16	Dishwashers					16
17	Maintenance Workers	3,819	4,124	51,908	12.59	17
18	Housekeepers	18,031	19,567	199,574	10.20	18
19	Laundry					19
20	Administrator	1,909	2,315	85,486	36.93	20
21	Assistant Administrator	2,495	2,726			21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,648	13,761	170,621	12.40	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	2,218	2,370	28,072	11.84	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	4,484	4,484	18,493	4.12	33
34	TOTAL (lines 1 - 33)	155,838	171,462	\$ 2,288,723 *	\$ 13.35	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	197	\$ 9,711	01-03	35
36	Medical Director	Monthly	7,500	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	9,176	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,244	11-03	44
45	Social Service Consultant				45
46	Other(specify) Specialized Rehab	Monthly	17,400	10a-03	46
47	Dir of Food Services	Monthly	17,400	01-03	47
48					48
49	TOTAL (lines 35 - 48)	197	\$ 102,743		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	868	31,975	10-03	51
52	Certified Nurse Assistants/Aides	48	1,352	10-03	52
53	TOTAL (lines 50 - 52)	916	\$ 33,327		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number				STATE OF ILLINOIS		Page 21		
Greenwood Care Ltd.				# 0031971		Report Period Beginning: 01/01/12 Ending: 12/31/12		
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 1/1/12- 8/19/12	Administrator	0	\$ 52,716	Workers' Compensation Insurance	\$ 36,943	IDPH License Fee	\$ 1,909	
Arleen Menchavez 8/20/12- Current	Administrator	0	32,769	Unemployment Compensation Insurance	37,128	Advertising: Employee Recruitment	528	
				FICA Taxes	170,039	Health Care Worker Background Check	2,909	
				Employee Health Insurance	183,275	(Indicate # of checks performed 290)		
				Employee Meals	19,087	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Permits	10,469	
				Union Pension Plan	21,350	Dues & Subscriptions	268	
				401K Matching Contributions	6,400	Allocated from SIR Management	344	
				Other Employee Benefits	3,394			
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 85,486					
B. Administrative - Other								
Description			Amount					
SIR Management - Consulting Fees			\$ 347,001			Less: Public Relations Expense	()	
SIR Management - Director of Administrative Services			34,800			Non-allowable advertising	()	
SIR Management - Ancillary Management Charges			37,500			Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 419,301	TOTAL (agree to Schedule V, line 22, col.8)	\$ 477,616	TOTAL (agree to Sch. V, line 20, col. 8)		
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount					
SIR Management	Accounting		\$ 36,000				Out-of-State Travel	\$
SIR Management	Dir of Regulatory Serivces		17,400					
SIR Management	Bookkeeping Fees		60,900					
See Attached	Legal Fees		8,290				In-State Travel	
Personnel Planners	Unemployment Tax Consult.		1,583					
Pinacle Consulting	Customer Satisfaction Program		2,504					
Frost, Ruttenberg, & Rothblatt	Accounting		13,124				Seminar Expense	2,595
Plante Moran	Accounting		1,444				Allocated from SIR Management	470
Rieff Schramm Kanter & Guttman	R/E Tax Legal Fees		8,164					
Olympic Engineering	Engineering Services		1,000					
See Supplemetal Schedule			2,246				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL	\$	(agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 152,654			TOTAL		\$ 3,065

* Attach copy of IMRF notifications

SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

* 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 \$13,388

(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.

\$15,026

Line10

(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?

YESXNO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YESNOX

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.

\$375,126

This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

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

Yes

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

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$19,087

Has any meal income been offset against related costs?

N/A

Indicate the amount. \$N/A

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period. \$N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

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