



Facility Name & ID Number GREENWOOD CARE, LTD.

# 0031971 Report Period Beginning: 01/01/00 Ending: 12/31/00

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 \_\_\_\_\_

	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			
		Public Aid Recipient	Private Pay	Other	
8	SNF	0			8
9	SNF/PED				9
10	ICF	47,604	1,294	109	49,007
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	47,604	1,294	109	49,007

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.34%

D. How many bed-hold days during this year were paid by Public Aid? 2,385 (Do not include bed-hold days in Section B.)

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

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

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

I. On what date did you start providing long term care at this location?  
Date started 02/01/87

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 02/01/87 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

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/00 Fiscal Year: 12/31/00

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

Facility Name &amp; ID Number GREENWOOD CARE, LTD.

# 0031971

Report Period Beginning:

01/01/00

Ending:

12/31/00

## 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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
<b>1</b>	<b>A. General Services</b>										
1	Dietary	129,043	16,181	24,396	169,620		169,620	(15,242)	154,378		1
2	Food Purchase		149,818		149,818	(11,913)	137,905	(39)	137,865		2
3	Housekeeping	115,303	20,445		135,748		135,748	444	136,192		3
4	Laundry		14,405	13,650	28,055		28,055		28,055		4
5	Heat and Other Utilities			110,847	110,847		110,847	1,629	112,476		5
6	Maintenance	34,545	21,362	186,501	242,408		242,408	(103,554)	138,854		6
7	Other (specify):*							5,693	5,693		7
<b>8</b>	<b>TOTAL General Services</b>	<b>278,891</b>	<b>222,211</b>	<b>335,394</b>	<b>836,496</b>	<b>(11,913)</b>	<b>824,583</b>	<b>(111,069)</b>	<b>713,513</b>		<b>8</b>
<b>9</b>	<b>B. Health Care and Programs</b>										
9	Medical Director			1,800	1,800		1,800		1,800		9
10	Nursing and Medical Records	648,320	15,336	64,174	727,830		727,830	(14,955)	712,875		10
10a	Therapy	48,693	2,640	17,226	68,559		68,559	(4,140)	64,419		10a
11	Activities	137,737	12,044	300	150,081		150,081	(40)	150,041		11
12	Social Services	178,154			178,154		178,154		178,154		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*							3,799	3,799		15
<b>16</b>	<b>TOTAL Health Care and Programs</b>	<b>1,012,904</b>	<b>30,020</b>	<b>83,500</b>	<b>1,126,424</b>		<b>1,126,424</b>	<b>(15,336)</b>	<b>1,111,088</b>		<b>16</b>
<b>17</b>	<b>C. General Administration</b>										
17	Administrative	62,009		362,321	424,330		424,330	(276,601)	147,729		17
18	Directors Fees										18
19	Professional Services			114,810	114,810		114,810	(63,955)	50,855		19
20	Dues, Fees, Subscriptions & Promotions			25,101	25,101		25,101	(1,283)	23,818		20
21	Clerical & General Office Expenses	112,619	21,380	50,112	184,111		184,111	19,738	203,849		21
22	Employee Benefits & Payroll Taxes			209,801	209,801	11,913	221,714		221,714		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,075	1,075		1,075	559	1,634		24
25	Other Admin. Staff Transportation							2,363	2,363		25
26	Insurance-Prop.Liab.Malpractice			42,907	42,907		42,907	800	43,707		26
27	Other (specify):*							17,995	17,995		27
<b>28</b>	<b>TOTAL General Administration</b>	<b>174,628</b>	<b>21,380</b>	<b>806,127</b>	<b>1,002,135</b>	<b>11,913</b>	<b>1,014,048</b>	<b>(300,384)</b>	<b>713,664</b>		<b>28</b>
<b>29</b>	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,466,423</b>	<b>273,611</b>	<b>1,225,021</b>	<b>2,965,055</b>		<b>2,965,055</b>	<b>(426,789)</b>	<b>2,538,266</b>		<b>29</b>

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

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

**GREENWOOD CARE, LTD.**  
**0031971**  
**COST REPORT RECLASSIFICATIONS**  
**01/01/00**  
**12/31/00**

SCHEDULE V LINE #
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22	EMPLOYEE BENEFITS	<u>11,913</u>	
2	FOOD		<u>11,913</u>

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	<u>          </u>	
19	PROFESSIONAL FEES		<u>          </u>

To reclass cost of appealing real estate taxes

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
30	<b>D. Ownership</b> Depreciation			86,421	86,421		86,421	49,005	135,426			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,142	1,142		1,142	359,642	360,784			32
33	Real Estate Taxes			131,235	131,235		131,235	3,321	134,556			33
34	Rent-Facility & Grounds			476,280	476,280		476,280	(476,280)				34
35	Rent-Equipment & Vehicles			7,559	7,559		7,559	7,742	15,301			35
36	Other (specify):*							8,459	8,459			36
37	<b>TOTAL Ownership</b>			702,637	702,637		702,637	(48,111)	654,526			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			79,606	79,606		79,606		79,606			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			79,606	79,606		79,606		79,606			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,466,423	273,611	2,007,264	3,747,298		3,747,298	(474,900)	3,272,398			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.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>OHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(32,868)	30		9
10	Interest and Other Investment Income	(7,304)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(39)	2		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	(131)	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	(9,991)	21		24
25	Fund Raising, Advertising and Promotional	(2,025)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(8,100)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(87,475)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (147,933)		\$	30

<b>OHF USE ONLY</b>							
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	2	
		<b>Amount</b>	<b>Reference</b>	
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)	(326,967)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (326,967)		36
	(sum of SUBTOTALS)			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (474,900)		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	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

ID# 0031971

Report Period Beginning: 01/01/00

Ending: 12/31/00

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Deferred Maintenance	\$	6
2	Repair and Maintenance(Capitalized)	(86,748)	6
3	HMO Patients' Expenses	(40)	11
4	Other Income	(469)	21
5	ICLIC COPE Contribution	(218)	20
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
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42			42
43			43
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68			68
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70			70
71			71
72			72
73			73
74			74
75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90	<b>Total</b>	(87,475)	90

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number GREENWOOD CARE, LTD.# 0031971 Report Period Beginning:01/01/00

Ending:

12/31/00

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary					(15,242)							(15,242)	1
2	Food Purchase	(39)											(39)	2
3	Housekeeping			444									444	3
4	Laundry													4
5	Heat and Other Utilities			599	1,030								1,629	5
6	Maintenance	(86,748)		369	(8,205)	(8,970)							(103,554)	6
7	Other (specify):*				553	5,140							5,693	7
8	<b>TOTAL General Services</b>	<b>(86,787)</b>		<b>1,412</b>	<b>(6,622)</b>	<b>(19,072)</b>							<b>(111,069)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records				(14,955)								(14,955)	10
10a	Therapy					(4,140)							(4,140)	10a
11	Activities	(40)											(40)	11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				2,329	1,470							3,799	15
16	<b>TOTAL Health Care and Programs</b>	<b>(40)</b>			<b>(12,626)</b>	<b>(2,670)</b>							<b>(15,336)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			10,357	(45,380)	(232,341)		(9,237)					(276,601)	17
18	Directors Fees													18
19	Professional Services			(62,622)	(10,059)	8,661		65					(63,955)	19
20	Fees, Subscriptions & Promotions	(2,374)		266	782			43					(1,283)	20
21	Clerical & General Office Expenses	(18,560)		34,391	3,813			94					19,738	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			135	424								559	24
25	Other Admin. Staff Transportation			471	1,892								2,363	25
26	Insurance-Prop.Liab.Malpractice			302	417			81					800	26
27	Other (specify):*			5,403	3,490	8,732		370					17,995	27
28	<b>TOTAL General Administration</b>	<b>(20,934)</b>		<b>(11,297)</b>	<b>(44,621)</b>	<b>(214,948)</b>		<b>(8,584)</b>					<b>(300,384)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(107,761)</b>		<b>(9,885)</b>	<b>(63,869)</b>	<b>(236,690)</b>		<b>(8,584)</b>					<b>(426,789)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number GREENWOOD CARE, LTD.# 0031971

Report Period Beginning:

01/01/00 Ending:12/31/00

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
<b>30</b>	<b>D. Ownership</b>													
	Depreciation	(32,868)	75,775	2,207	3,891								49,005	30
<b>31</b>	Amortization of Pre-Op. & Org.													31
<b>32</b>	Interest	(7,304)	363,719	861	2,305			61					359,642	32
<b>33</b>	Real Estate Taxes			1,114	2,207								3,321	33
<b>34</b>	Rent-Facility & Grounds		(476,280)										(476,280)	34
<b>35</b>	Rent-Equipment & Vehicles			1,905	4,711			1,126					7,742	35
<b>36</b>	Other (specify):*		8,459										8,459	36
<b>37</b>	<b>TOTAL Ownership</b>	(40,172)	(28,327)	6,087	13,114			1,187					(48,111)	37
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
<b>38</b>	Medically Necessary Transportation													38
<b>39</b>	Ancillary Service Centers													39
<b>40</b>	Barber and Beauty Shops													40
<b>41</b>	Coffee and Gift Shops													41
<b>42</b>	Provider Participation Fee													42
<b>43</b>	Other (specify):*													43
<b>44</b>	<b>TOTAL Special Cost Centers</b>													44
<b>45</b>	<b>GRAND TOTAL COST</b>													
	(sum of lines 29, 37 & 44)	(147,933)	(28,327)	(3,798)	(50,755)	(236,690)		(7,397)					(474,900)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Schedule Attached		See Schedule Attached		See Schedule Attached		
				GREENWOOD		
				CARE LLC	EVANSTON	BUILDING CO.

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 Rental Income	\$ 476,280	Grenwood Care LLC	100.00%	\$	\$ (476,280)	1
2	V	32 Interest Income	230	Grenwood Care LLC	100.00%		(230)	2
3	V	32 Interest Expense		Grenwood Care LLC	100.00%	363,949	363,949	3
4	V	30 Depreciation		Grenwood Care LLC	100.00%	75,775	75,775	4
5	V	36 Amortization		Grenwood Care LLC	100.00%	8,459	8,459	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 476,510			\$ 448,183	\$ * (28,327)	14

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

**VII. RELATED PARTIES (continued)**

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**  YES  NO

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
		Item			Name of Related Organization						
15	V	3	HOUSEKEEPING	\$		PREFERRED BOOKKEEPING	100.00%	\$ 444	444	15	
16	V	5	UTILITIES			PREFERRED BOOKKEEPING	100.00%	599	599	16	
17	V	6	REPAIRS AND MAINT.			PREFERRED BOOKKEEPING	100.00%	369	369	17	
18	V	17	ADMIN. FINANCIAL SAL.			PREFERRED BOOKKEEPING	100.00%	10,357	10,357	18	
19	V	19	PROFESSIONAL FEES			PREFERRED BOOKKEEPING	100.00%	1,378	1,378	19	
20	V	20	DUES,SUBSCRIPTIONS			PREFERRED BOOKKEEPING	100.00%	266	266	20	
21	V	21	CLERICAL			PREFERRED BOOKKEEPING	100.00%	34,391	34,391	21	
22	V	24	SEMINARS			PREFERRED BOOKKEEPING	100.00%	135	135	22	
23	V	25	ADMIN. STAFF TRAVEL			PREFERRED BOOKKEEPING	100.00%	471	471	23	
24	V	26	INSURANCE			PREFERRED BOOKKEEPING	100.00%	302	302	24	
25	V	27	EMPLOYEE BENEFITS			PREFERRED BOOKKEEPING	100.00%	5,403	5,403	25	
26	V	30	DEPRECIATION			PREFERRED BOOKKEEPING	100.00%	2,207	2,207	26	
27	V	32	INTEREST			PREFERRED BOOKKEEPING	100.00%	861	861	27	
28	V	33	REAL ESTATE TAXES			PREFERRED BOOKKEEPING	100.00%	1,114	1,114	28	
29	V	35	EQUIPMENT RENTAL			PREFERRED BOOKKEEPING	100.00%	1,905	1,905	29	
30	V									30	
31	V									31	
32	V	19	ACCOUNT/BOOKKEEPING		64,000	PREFERRED BOOKKEEPING	100.00%		(64,000)	32	
33	V	19	COMPUTER		3,480	PREFERRED BOOKKEEPING	100.00%	3,480		33	
34	V									34	
35	V									35	
36	V									36	
37	V									37	
38	V									38	
39	<b>Total</b>			\$	67,480			\$ 63,682	\$ *	(3,798)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization		8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
		Item	Amount	Name of Related Organization							
15	V	5	UTILITIES	\$		S.I.R. MANAGEMENT, INC.	100.00%	\$ 1,030	\$	1,030	15
16	V	6	REPAIRS AND MAINT.		13,056	S.I.R. MANAGEMENT, INC.	100.00%	4,851		(8,205)	16
17	V	7	EMP. BEN.-GEN. SERV.			S.I.R. MANAGEMENT, INC.	100.00%	553		553	17
18	V	10	NURSING		28,716	S.I.R. MANAGEMENT, INC.	100.00%	13,761		(14,955)	18
19	V	15	EMP. BEN.-H.C.			S.I.R. MANAGEMENT, INC.	100.00%	2,329		2,329	19
20	V	17	ADMINISTRATIVE		50,868	S.I.R. MANAGEMENT, INC.	100.00%	5,488		(45,380)	20
21	V	19	PROFESSIONAL FEES		11,748	S.I.R. MANAGEMENT, INC.	100.00%	1,689		(10,059)	21
22	V	20	FEES,SUBSCRIPTIONS			S.I.R. MANAGEMENT, INC.	100.00%	782		782	22
23	V	21	CLERICAL & GENERAL		14,796	S.I.R. MANAGEMENT, INC.	100.00%	18,609		3,813	23
24	V	24	EDUCATION & SEMINAR			S.I.R. MANAGEMENT, INC.	100.00%	424		424	24
25	V	25	OTHER ADMIN. STAFF TRANS.			S.I.R. MANAGEMENT, INC.	100.00%	1,892		1,892	25
26	V	26	INSURANCE			S.I.R. MANAGEMENT, INC.	100.00%	417		417	26
27	V	27	EMP. BEN.-GEN. ADMIN.			S.I.R. MANAGEMENT, INC.	100.00%	3,490		3,490	27
28	V	30	DEPRECIATION			S.I.R. MANAGEMENT, INC.	100.00%	3,891		3,891	28
29	V	32	INTEREST			S.I.R. MANAGEMENT, INC.	100.00%	2,305		2,305	29
30	V	33	REAL ESTATE TAXES			S.I.R. MANAGEMENT, INC.	100.00%	2,207		2,207	30
31	V	35	EQUIPMENT RENTAL			S.I.R. MANAGEMENT, INC.	100.00%	4,711		4,711	31
32	V										32
33	V										33
34	V										34
35	V										35
36	V										36
37	V										37
38	V										38
39	Total			\$	119,184			\$ 68,429	\$ *	(50,755)	39

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

**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	\$ 14,796	S.I.R. MANAGEMENT, INC.	100.00%	\$ 3,973	\$ (10,823)	15
16	V	7 EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	669	669	16
17	V	17 ADMIN./LEGAL SALARIES	295,728	S.I.R. MANAGEMENT, INC.	100.00%	63,387	(232,341)	17
18	V	19 FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	8,661	8,661	18
19	V	27 EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	8,732	8,732	19
20	V							20
21	V							21
22	V	10A SPECIAL REHAB	12,876	S.I.R. MANAGEMENT, INC.	100.00%	8,736	(4,140)	22
23	V	15 EMP. BEN.-HEALTH CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	1,470	1,470	23
24	V							24
25	V							25
26	V	6 REPAIRS AND MAINT.	29,504	S.I.R. MANAGEMENT, INC.	100.00%	20,534	(8,970)	26
27	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	3,575	3,575	27
28	V							28
29	V							29
30	V	1 DIETICIAN SALARIES	9,600	S.I.R. MANAGEMENT, INC.	100.00%	5,181	(4,419)	30
31	V	7 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	896	896	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$ 362,504			\$ 125,814	\$ * (236,690)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
		Item	Amount	Name of Related Organization						
15	V	22	EMPLOYEE HEALTH INS.	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 54,097	\$	54,097	15
16	V									16
17	V									17
18	V									18
19	V	22	EMPLOYEE HEALTH INS.	54,097	CCS EMPLOYEE BENEFIT GROUP	100.00%			(54,097)	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			\$ 54,097			\$ 54,097	\$ *		39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
		Item	Amount	Name of Related Organization						
15	V	19	PROFESSIONAL FEES	\$		100.00%	\$ 65	\$	65	15
16	V	20	DUES, FEES & SUBSCRIPTIONS			100.00%	43		43	16
17	V	21	CLERICAL			100.00%	94		94	17
18	V	26	INSURANCE			100.00%	81		81	18
19	V	32	INTEREST			100.00%	61		61	19
20	V	35	VEHICLE RENTAL			100.00%	1,126		1,126	20
21	V	17	MANAGEMENT FEES	15,600		100.00%			(15,600)	21
22	V									22
23	V	17	ADMIN. SAL. - M. GIANNINI			100.00%	6,363		6,363	23
24	V	27	EMP. BEN. - M. GIANNINI			100.00%	370		370	24
25	V	17	ADMIN. SALARY			100.00%	0			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			\$ 15,600			\$ 8,203	\$ *	(7,397)	39

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

**VII. RELATED PARTIES (continued)**

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**  YES  NO

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
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	<b>Total</b>		\$				\$	0 \$ *	39

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

**VII. RELATED PARTIES (continued)**

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**  YES  NO

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
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	<b>Total</b>		\$				\$	0 \$ *	39

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

**VII. RELATED PARTIES (continued)**

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**  YES  NO

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
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	<b>Total</b>		\$				\$	0 \$ *	39

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

**VII. RELATED PARTIES (continued)**

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**  YES  NO

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
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	<b>Total</b>		\$				\$	0 \$ *	39

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

Facility Name & ID Number GREENWOOD CARE, LTD. # 0031971 Report Period Beginning: 01/01/00 Ending: 12/31/00

## 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	Eric Rothner	Stockholder	Administrative	51.72%	see attached	0.48	0.67%	alloc SIR	\$ 5,101	17-7	1
2	Bryan Barrish	Stockholder	Administrative	31.03%	see attached	3.43	6.86%	alloc SIR	20,034	17-7	2
3	Mike Giannini	Stockholder	Administrative	3.45%	see attached	3.05	6.10%	alloc SIR/OC	18,326	17-7	3
4	Louise Bergthold	Stockholder	Administrative	3.45%	see attached	4.19	7.61%	alloc SIR	12,961	17-7	4
5	Arturo Rominiquilt	Relative	Courier	0.00%	see attached	2.91	7.27%	alloc Pref.Bkg	1,593	21-7	5
6	Nenita Guzman	Relative	Dietary	0.00%	see attached	4.19	7.61%	alloc SIR	3,973	1-7	6
7	Tom Winter	Stockholder	Administrative	0.58%	see attached	4.37	7.28%	alloc Pref.Bkg	10,357	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 72,345		13

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

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

Facility Name & ID Number GREENWOOD CARE, LTD.

# 0031971

Report Period Beginning:

01/01/00

Ending: 12/31/00

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number GREENWOOD CARE, LTD.

# 0031971

Report Period Beginning:

01/01/00

Ending: 12/31/00

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 PREFERRED BOOKEEPING SERVICES  
 Street Address 4100 WEST PRATT AVE.  
 City / State / Zip Code LINCOLNWOOD, IL. 60712  
 Phone Number ( 847) 674-5200  
 Fax Number ( 847) 674-5267

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	3	HOUSEKEEPING	BOOK./ACCNT.INCOME 878,492	11	\$ 6,088	\$	64,000	\$ 444	1
2	5	UTILITIES	BOOK./ACCNT.INCOME 878,492	11	8,220		64,000	599	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME 878,492	11	5,069		64,000	369	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME 878,492	11	142,165	142,165	64,000	10,357	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME 878,492	11	18,910		64,000	1,378	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME 878,492	11	3,657		64,000	266	6
7	21	CLERICAL	BOOK./ACCNT.INCOME 878,492	11	472,061	403,426	64,000	34,391	7
8	24	SEMINARS	BOOK./ACCNT.INCOME 878,492	11	1,858		64,000	135	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME 878,492	11	6,465		64,000	471	9
10	26	INSURANCE	BOOK./ACCNT.INCOME 878,492	11	4,146		64,000	302	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME 878,492	11	74,163		64,000	5,403	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME 878,492	11	30,298		64,000	2,207	12
13	32	INTEREST	BOOK./ACCNT.INCOME 878,492	11	11,823		64,000	861	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME 878,492	11	15,297		64,000	1,114	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME 878,492	11	26,147		64,000	1,905	15
16									16
17									17
18									18
19	19	COMPUTER	DIRECT ALLOCATION					3,480	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 826,367	\$ 545,591		\$ 63,682	25

Facility Name & ID Number GREENWOOD CARE, LTD.

# 0031971 Report Period Beginning: 01/01/00

Ending: 12/31/00

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 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	5	UTILITIES	PATIENT DAYS	642,911	10	\$ 13,508	\$ 49,007	\$ 1,030	1	
2	6	REPAIRS AND MAINT.	PATIENT DAYS	642,911	10	63,644	42,834	49,007	4,851	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	642,911	10	7,250		49,007	553	3
4	10	NURSING	PATIENT DAYS	642,911	10	180,529	180,529	49,007	13,761	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	642,911	10	30,553		49,007	2,329	5
6	17	ADMINISTRATIVE	PATIENT DAYS	642,911	10	71,994	71,994	49,007	5,488	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	642,911	10	22,153		49,007	1,689	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	642,911	10	10,256		49,007	782	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	642,911	10	244,124	177,193	49,007	18,609	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	642,911	10	5,556		49,007	424	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	642,911	10	24,821		49,007	1,892	11
12	26	INSURANCE	PATIENT DAYS	642,911	10	5,468		49,007	417	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	642,911	10	45,778		49,007	3,490	13
14	30	DEPRECIATION	PATIENT DAYS	642,911	10	51,045		49,007	3,891	14
15	32	INTEREST	PATIENT DAYS	642,911	10	30,234		49,007	2,305	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	642,911	10	28,948		49,007	2,207	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	642,911	10	61,803		49,007	4,711	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 897,664	\$ 472,550		\$ 68,429	25

Facility Name & ID Number GREENWOOD CARE, LTD.

# 0031971 Report Period Beginning: 01/01/00

Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	10	\$ 52,122	\$ 52,122	49,007	\$ 3,973	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	10	8,770		49,007	669	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	10	831,558	831,558	49,007	63,387	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	10	113,620		49,007	8,661	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	10	\$ 114,558	\$	49,007	\$ 8,732	5
6									6
7									7
8	10A	SPECIAL REHAB	SPECIAL REHAB INC.	4	56,277	56,277	12,876	8,736	8
9	15	EMP. BEN.-HEALTH CARE & P	SPECIAL REHAB INC.	4	\$ 9,470	\$	12,876	\$ 1,470	9
10									10
11									11
12	6	REPAIRS AND MAINT.	MAINTENANCE INC.	10	165,366	165,366	29,504	20,534	12
13	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	10	\$ 28,790	\$	29,504	\$ 3,575	13
14									14
15									15
16	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	10	67,672	67,672	9,600	5,181	16
17	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	10	11,698		9,600	896	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,459,901	\$ 1,172,995		\$ 125,814	25

Facility Name & ID Number GREENWOOD CARE, LTD.

# 0031971 Report Period Beginning: 01/01/00

Ending: 12/31/00

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 4101 W. MAIN ST.  
 City / State / Zip Code SKOKIE, IL 60076  
 Phone Number ( 847) 674-1180  
 Fax Number ( 847) 673-7741

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 INS.	DIRECT ALLOCATION		\$	\$		\$ 54,097	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				\$	\$		\$ 54,097	25

Facility Name & ID Number GREENWOOD CARE, LTD.

# 0031971 Report Period Beginning: 01/01/00

Ending: 12/31/00

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 ECM OWNERS COUNCIL  
 Street Address 6840 N. LINCOLN  
 City / State / Zip Code LINCOLNWOOD, IL. 60712  
 Phone Number ( 847) 676-2026  
 Fax Number (

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	ECMOC MGMNT FEE INC. 96,000	9	\$ 400	\$	15,600	\$ 65	1
2	20	DUES, FEES & SUBSCRIPTION	ECMOC MGMNT FEE INC. 96,000	9	264		15,600	43	2
3	21	CLERICAL	ECMOC MGMNT FEE INC. 96,000	9	579		15,600	94	3
4	26	INSURANCE	ECMOC MGMNT FEE INC. 96,000	9	496		15,600	81	4
5	32	INTEREST	ECMOC MGMNT FEE INC. 96,000	9	374		15,600	61	5
6	35	VEHICLE RENTAL	ECMOC MGMNT FEE INC. 96,000	9	6,931		15,600	1,126	6
7									7
8									8
9	17	ADMIN. SAL. - M. GIANNINI	ADMIN. HOURS 39	9	81,858	81,858	3	6,363	9
10	27	EMP. BEN. - M. GIANNINI	ADMIN. HOURS 39	9	4,762		3	370	10
11	17	ADMIN. SALARY	DIRECT ALLOCATION						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				\$ 95,664	\$ 81,858		\$ 8,203	25

Facility Name & ID Number GREENWOOD CARE, LTD.

# 0031971 Report Period Beginning: 01/01/00

Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number GREENWOOD CARE, LTD.

# 0031971 Report Period Beginning: 01/01/00

Ending: 12/31/00

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number GREENWOOD CARE, LTD.

# 0031971 Report Period Beginning: 01/01/00

Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number GREENWOOD CARE, LTD.

# 0031971 Report Period Beginning: 01/01/00

Ending: 12/31/00

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	<b>TOTALS</b>				\$	\$		\$	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										
										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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	Nomura	X		Mortgage	\$35,561.00	03/01/95	\$	\$ 4,085,279		8.6900	\$ 363,949	1							
2												2							
3												3							
4												4							
5												5							
<b>Working Capital</b>																			
6	CIB Bank/S.I.R. Line		X	Line of Credit				145,000				6							
7	Horton Insurance		X	Insurance Premiums							1,142	7							
8												8							
9	<b>TOTAL Facility Related</b>				\$35,561.00		\$	\$ 4,230,279			\$ 365,091	9							
<b>B. Non-Facility Related*</b>																			
10	Supplemental Schedule										(4,307)	10							
11												11							
12												12							
13												13							
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (4,307)	14							
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 4,230,279			\$ 360,784	15							

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

(See instructions.)

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

(See instructions.)

Facility Name & ID Number

GREENWOOD CARE, LTD.

# 0031971

Report Period Beginning:

01/01/00

Ending:

12/31/00

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	Name of Lender	2		3	4	5	6		7	8	9	10	11					
		Related**					Monthly Payment Required	Date of Note						Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
1	Interest Income						\$	\$					\$ (7,304)	1				
2	Alloc - Preferred Bookkeeping	X											861	2				
3	Interest Income -Bldg												(230)	3				
4	Alloc. - SIR Mgmt	X											2,305	4				
5	Alloc - ECM Owners Council	X											61	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							\$	\$					\$ (4,307)	21				



X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,467 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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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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:

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

Facility Name & ID Number **GREENWOOD CARE, LTD.**# **0031971**

Report Period Beginning:

01/01/00

Ending:

12/31/00

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	145		1990		\$ 1,845,500	\$ 75,775	35	\$ 52,729	\$ (23,046)	\$ 765,108	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various		1984		2,672		20	76	76	1,115	9
10	Various		1987		24,869	771	20	723	(48)	8,676	10
11	Various		1988		27,733	446	20	1,146	700	9,707	11
12	Various		1989		21,624	444	20	1,016	572	9,137	12
13	Various		1990		27,300	311	20	1,365	1,054	15,652	13
14	Various		1991		9,846	115	20	491	376	5,431	14
15	Various		1992		25,025	307	20	1,244	937	11,303	15
16	Various		1993		63,911	818	20	3,195	2,377	24,769	16
17	Various		1994		20,319	126	20	1,017	891	6,491	17
18	Various		1995		73,839	2,148	20	3,693	1,545	20,647	18
19	RENOVATION WORK		1996		23,267	597	20	1,163	566	5,524	19
20	CARPETING		1996		17,300	1,993	20	865	(1,128)	3,676	20
21	SMOKE DETECTORS		1996		3,650	421	20	183	(238)	808	21
22	ELECTRICAL WIRING		1996		53,063	1,361	20	2,653	1,292	12,160	22
23	ASBESTOS PROGRAM		1996		11,940	306	20	597	291	2,687	23
24											24
25	PAGE 12-I REP TOTALS				61,393	2,540		2,391	(149)	13,466	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33	PAGE 12C TOTALS				36,219	4,352		1,106	(3,246)	1,106	33
34	PAGE 12B TOTALS				243,483	17,787		10,629	(7,158)	12,119	34
35	PAGE 12A TOTALS				216,015	4,068		10,801	6,733	24,448	35
36	TOTAL (lines 4 thru 35)				\$ 2,808,968	\$ 114,686		\$ 97,083	\$ (17,603)	\$ 954,030	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:

01/01/00

Ending:

12/31/00

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		<b>FIRE DOOR</b>		1997	1,264	139	20	63	(76)	247	9
10		<b>CEILING TILE</b>		1997	895		20	45	45	180	10
11		<b>6 BIRCH DOORS</b>		1997	4,063	462	20	203	(259)	727	11
12		<b>ELEVATOR UPKEEP</b>		1997	9,000	231	20	450	219	1,650	12
13		<b>TUCKPOINTING</b>		1997	18,000	462	20	900	438	3,375	13
14		<b>REPLACEMENT WINDOWS</b>		1997	5,960	153	20	298	145	1,068	14
15		<b>FLOORING</b>		1997	10,997	1,504	20	550	(954)	1,742	15
16		<b>BLINDS</b>		1997	4,939		20	247	247	844	16
17		<b>VALANCES</b>		1997	8,560		20	428	428	1,462	17
18		<b>WALLCOVERING</b>		1997	4,207		20	210	210	648	18
19		<b>PAINTING</b>		1997	2,765		20	138	138	495	19
20		<b>BLINDS</b>		1997	2,521		20	126	126	389	20
21		<b>FIRE SYSTEM</b>		1998	7,000	179	20	350	171	846	21
22		<b>SEWER WORK</b>		1998	4,800	123	20	240	117	640	22
23		<b>ROOFING</b>		1998	15,300	392	20	765	373	1,849	23
24		<b>CONCRETE FLOOR</b>		1998	2,400		20	120	120	260	24
25		<b>TILE, CONCRETE</b>		1998	2,600		20	130	130	293	25
26		<b>ROOF DRAIN</b>		1998	3,000		20	150	150	350	26
27		<b>MAGNETIC DOOR HOLDER</b>		1998	1,523		20	76	76	203	27
28		<b>ROOFING</b>		1998	12,000	308	20	600	292	1,550	28
29		<b>RADIATOR COVERS</b>		1998	2,290		20	115	115	335	29
30		<b>WINDOWS</b>		1998	2,970		20	149	149	348	30
31		<b>ROOM DIVIDERS</b>		1998	4,488	115	20	224	109	560	31
32		<b>PAINTING</b>		1999	45,426		20	2,271	2,271	2,271	32
33		<b>PAINTING</b>		1999	34,697		20	1,735	1,735	1,880	33
34		<b>ASBESTOS ABATEMENT</b>		1999	2,940		20	147	147	159	34
35		<b>CONDENSATE PUMP</b>		1999	1,410		20	71	71	77	35
36		<b>TOTAL (lines 4 thru 35)</b>			\$ 216,015	\$ 4,068		\$ 10,801	\$ 6,733	\$ 24,448	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:

01/01/00

Ending:

12/31/00

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		<b>CUBICLE CURTAINS</b>		1999	11,333	4,306	20	567	(3,739)	567	9
10		<b>PAINTING</b>		1999	28,077		20	1,404	1,404	1,521	10
11		<b>CALL SYSTEM</b>		1999	2,294	872	20	115	(757)	144	11
12		<b>FLOORING</b>		1999	1,537		20	77	77	141	12
13		<b>S.I.R. ALLOCATION</b>		1999	8,112	208	20	406	198	508	13
14		<b>BOILER</b>		1999	18,800	7,984	20	940	(7,044)	1,175	14
15		<b>ELEVATOR WORK</b>		1999	3,215	964	20	161	(803)	282	15
16		<b>FIRE DAMPERS</b>		1999	27,200	697	20	1,360	663	2,153	16
17		<b>FLOORING</b>		1999	6,258	140	20	313	173	313	17
18		<b>ELEVATOR REPAIR</b>		1999	1,000		20	50	50	79	18
19		<b>BOILER WORK</b>		2000	1,600		20	67	67	67	19
20		<b>PEDESTRIAN DOOR</b>		2000	2,988	598	20	25	(573)	25	20
21		<b>TILE WORK</b>		2000	49,747	691	20	1,451	760	1,451	21
22		<b>PAINTING</b>		2000	5,831		20	292	292	292	22
23		<b>BOILER WORK</b>		2000	1,240		20	57	57	57	23
24		<b>PHONE LINES</b>		2000	1,128		20	56	56	56	24
25		<b>FLOORING - WALLBASE</b>		2000	3,637	74	20	152	78	152	25
26		<b>FLOORING</b>		2000	7,498	184	20	375	191	375	26
27		<b>FLOORING</b>		2000	13,842	311	20	634	323	634	27
28		<b>TILE WORK</b>		2000	3,700		20	46	46	46	28
29		<b>TILE</b>		2000	569		20	21	21	21	29
30		<b>FLOORING</b>		2000	30,830	758	20	1,542	784	1,542	30
31		<b>FLOORING</b>		2000	5,016		20	230	230	230	31
32		<b>PLUMBING</b>		2000	1,285		20	54	54	54	32
33		<b>RADIATOR COVERS</b>		2000	540		20	22	22	22	33
34		<b>FRAMES/ROOM SIGNES</b>		2000	1,313		20	49	49	49	34
35		<b>WINDOW TREATMENT</b>		2000	4,893		20	163	163	163	35
36		<b>TOTAL (lines 4 thru 35)</b>			\$ 243,483	\$ 17,787		\$ 10,629	\$ (7,158)	\$ 12,119	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:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		<b>WINDOW TREATMENTS</b>		2000	1,274		20	16	16	16	9
10		<b>ROOM DIVIDERS</b>		2000	21,761	4,352	20	635	(3,717)	635	10
11		<b>CORIAN TOP</b>		2000	1,224		20	51	51	51	11
12		<b>TILE WORK</b>		2000	659		20	33	33	33	12
13		<b>BATHROOM WORK</b>		2000	1,442		20	18	18	18	13
14											14
15		<b>PAINTING</b>		2000	5,667		20	283	283	283	15
16		<b>WINDOWS</b>		2000	4,192		20	70	70	70	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36		<b>TOTAL (lines 4 thru 35)</b>			\$ 36,219	\$ 4,352		\$ 1,106	\$ (3,246)	\$ 1,106	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:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
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											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
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											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
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											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
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											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
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											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
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											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
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											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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 &amp; ID Number GREENWOOD CARE, LTD.

# 0031971

Report Period Beginning:

01/01/00

Ending:

12/31/00

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1993	alloc SIR	\$ 20,368	\$ 647	35	\$ 582	\$ (65)	\$ 4,365	4
5			1993	alloc SIR	10,287	327	35	294	(33)	2,204	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Allocated from Preferred Bookkeeping	1997		12,847	484	20	642	158	2,447	9
10		Allocated from Preferred Bookkeeping	1999		102	33	20	5	(28)	8	10
11		Allocated from Preferred Bookkeeping	2000		644		20	13	13	13	11
12		Allocated from SIR Management	1993		8,748	291	20	441	150	3,448	12
13		Allocated from SIR Management	1994		27		20	3	3	17	13
14		Allocated from SIR Management	1995		200	12	20	10	(2)	54	14
15		Allocated from SIR Management	1999		950	63	20	48	(15)	58	15
16		Allocated from SIR Management	2000		574	63	20	20	(43)	20	16
17		Allocated from SIR Properties/SIR Mgmt	1993		330	18	20	17	(1)	124	17
18		Allocated from SIR Properties/SIR Mgmt	1994		194	5	20	10	5	63	18
19		Allocated from SIR Properties/SIR Mgmt	1997		77	8	20	4	(4)	17	19
20		Allocated from SIR Properties/SIR Mgmt	1998		1,233	123	20	62	(61)	154	20
21		Allocated from SIR Properties/SIR Mgmt	1999		2,581	258	20	129	(129)	194	21
22		Allocated from SIR Properties/Pref. Book	1993		167	9	20	8	(1)	63	22
23		Allocated from SIR Properties/Pref. Book	1994		98	3	20	5	2	32	23
24		Allocated from SIR Properties/Pref. Book	1997		39	4	20	2	(2)	9	24
25		Allocated from SIR Properties/Pref. Book	1998		623	62	20	31	(31)	78	25
26		Allocated from SIR Properties/Pref. Book	1999		1,304	130	20	65	(65)	98	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36		TOTAL (lines 4 thru 35)			\$ 61,393	\$ 2,540		\$ 2,391	\$ (149)	\$ 13,466	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:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
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											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	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:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 399,858	\$ 36,591	\$ 30,388	\$ (6,203)		\$ 230,992	37
38	Current Year Purchases	94,684	13,495	7,918	(5,577)		7,918	38
39	Fully Depreciated Assets	107,601	3,522	37	(3,485)		8,667	39
40								40
41	TOTALS	\$ 602,143	\$ 53,608	\$ 38,343	\$ (15,265)		\$ 247,577	41

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 3,563,666	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 168,294	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 135,426	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (32,868)	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,201,607	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

\* 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.

**GREENWOOD CARE, LTD.**  
**0031971**  
**RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE**  
**12/31/00**

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
<b>LINE 28: PRIOR YEARS</b>					
Greenwood Care, Inc.	356,056	33,275	26,115	(7,160)	203,362
Greenwood Care LLC					
Alloc-Preferred Bookkeeping	14,924	1,069	1,385	316	9,154
Alloc-SIR Management	28,849	2,247	2,885	638	18,455
Alloc-SIR Properties-SIR Mgmt	19		2	2	14
Alloc-SIR Properties-Preferred Bookkeeping	10		1	1	7
<b>TOTALS</b>	<b>399,858</b>	<b>36,591</b>	<b>30,388</b>	<b>(6,203)</b>	<b>230,992</b>

**LINE 29: CURRENT YEAR**

Greenwood Care, Inc.	93,344	13,250	7,838	(5,412)	7,838
Greenwood Care LLC					
Alloc-Preferred Bookkeeping	435	87	36	(51)	36
Alloc-SIR Management	905	158	44	(114)	44
Alloc-SIR Properties-SIR Mgmt					
Alloc-SIR Properties-Preferred Bookkeeping					
<b>TOTALS</b>	<b>94,684</b>	<b>13,495</b>	<b>7,918</b>	<b>(5,577)</b>	<b>7,918</b>

**LINE 30: FULLY DEPRECIATED**

Greenwood Care, Inc.	8,667	3,522	37	(3,485)	8,667
Greenwood Care LLC	98,934				
Alloc-Preferred Bookkeeping					
Alloc-SIR Management					
Alloc-SIR Properties-SIR Mgmt					
Alloc-SIR Properties-Preferred Bookkeeping					
<b>TOTALS</b>	<b>107,601</b>	<b>3,522</b>	<b>37</b>	<b>(3,485)</b>	<b>8,667</b>

**TOTALS (Should Tie to Totals on Page 13)**

Greenwood Care, Inc.	458,067	50,047	33,990	(16,057)	219,867
Greenwood Care LLC	98,934				
Alloc-Preferred Bookkeeping	15,359	1,156	1,421	265	9,190
Alloc-SIR Management	29,754	2,405	2,929	524	18,499
Alloc-SIR Properties-SIR Mgmt	19		2	2	14
Alloc-SIR Properties-Preferred Bookkeeping	10		1	1	7
<b>TOTALS</b>	<b>602,143</b>	<b>53,608</b>	<b>38,343</b>	<b>(15,265)</b>	<b>247,577</b>

Facility Name & ID Number **GREENWOOD CARE, LTD.**

# **0031971**

Report Period Beginning:

**01/01/00**

Ending: **12/31/00**

**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 Date of Lease	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	<b>TOTAL</b>				\$			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: \$ 8,186

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	<u>Alloc. SIR Management</u>		\$	\$ <u>4,531</u>	17
18	<u>Alloc. EMC Owners Council</u>			<u>1,126</u>	18
19	<u>Alloc. Preferred Book</u>			<u>1,458</u>	19
20					20
21	<b>TOTAL</b>		\$	\$ <u>7,115</u>	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. \_\_\_\_\_/2001 \$ \_\_\_\_\_

13. \_\_\_\_\_/2002 \$ \_\_\_\_\_

14. \_\_\_\_\_/2003 \$ \_\_\_\_\_

\* 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 aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

	Facility			
	1	2	3	4
	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 Nurse Aide Competency Tests				
9 TOTALS	\$	\$	\$	\$
10 SUM OF line 9, col. 1 and 2 (e)	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF AIDES TRAINED**

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

- (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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

1	Service	Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or) Allocated	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	N/A	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <b>SCHEDULE**</b>									13
14	<b>TOTAL</b>			\$		\$	\$		\$	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 nurse aides, who help with the above activities should not be listed on this schedule.

**SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES**

<u>Special Services - Supplies (Column 6 - Other)</u>	<u>Amount</u>
1 Medical Supplies	
2 Complex Medical Equip	
3 Oxygen	
4 Equipment Rental	
5	
6	
7	
8	
9	
10	
	<u>                    </u>
	<u>                    </u>

<u>Outside Therapies (Column 5 - Other)</u>	<u>Amount</u>
1 Respiratory Therapy	
2	
3	
4	
5	
6	
7	
8	
9	
10	
	<u>                    </u>
	<u>                    </u>

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

	1	2	
	Operating	After Consolidation*	
<b>A. Current Assets</b>			
1 Cash on Hand and in Banks	\$ 56,003	\$ 61,176	1
2 Cash-Patient Deposits	7,397	7,397	2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance )	523,960	523,960	3
4 Supply Inventory (priced at )			4
5 Short-Term Investments			5
6 Prepaid Insurance	2,489	2,489	6
7 Other Prepaid Expenses	2,075	2,075	7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify): <a href="#">See supplemental schedule</a>	35,643	35,643	9
<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 627,567	\$ 632,740	10
<b>B. Long-Term Assets</b>			
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 Cos	487,181	487,181	15
16 Equipment, at Historical Cost	646,879	741,135	16
17 Accumulated Depreciation (book methods)	(551,095)	(1,316,203)	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): <a href="#">See supplemental schedule</a>	3,021	63,296	23
<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 585,986	\$ 2,402,026	24
<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,213,553	\$ 3,034,766	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26 Accounts Payable	\$ 117,478	\$ 117,478	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	8,962	8,962	28
29 Short-Term Notes Payable	145,000	145,000	29
30 Accrued Salaries Payable	102,296	102,296	30
31 Accrued Taxes Payable (excluding real estate taxes)	8,053	8,053	31
32 Accrued Real Estate Taxes(Sch.IX-B)	132,300	132,300	32
33 Accrued Interest Payable		20,709	33
34 Deferred Compensation			34
35 Federal and State Income Taxes	10,200	10,200	35
<b>Other Current Liabilities(specify):</b>			
36 <a href="#">See supplemental schedule</a>	4,865	4,865	36
37			37
<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 529,154	\$ 549,863	38
<b>D. Long-Term Liabilities</b>			
39 Long-Term Notes Payable			39
40 Mortgage Payable		4,085,279	40
41 Bonds Payable			41
42 Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>			
43 <a href="#">See supplemental schedule</a>			43
44			44
<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 4,085,279	45
<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 529,154	\$ 4,635,142	46
47 <b>TOTAL EQUITY</b> (page 18, line 24)	\$ 684,399	\$ #REF!	47
48 <b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,213,553	\$ #REF!	48

\*(See instructions.)

Facility Name & ID Number **GREENWOOD CARE, LTD.**

# **0031971**

Report Period Beginning: **01/01/00**

Ending:

**12/31/00**

**SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES**

As of **12/31/00**

OTHER CURRENT ASSETS:

Real Estate Tax Escrow

Amount

35,643

Amount

35,643

OTHER CURRENT LIABILITIES:

Due to Others

Amount

4,865

Amount

4,865

35,643

35,643

4,865

4,865

OTHER NON CURRENT ASSETS:

Capital Reserve

3,021

3,021

Loan Costs - Net

60,275

OTHER NON CURRENT LIABILITIES:

3,021

63,296

\_\_\_\_\_

\_\_\_\_\_

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b>	
		<b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>614,358</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<a href="#">Schedule attached</a>		<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>614,358</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>534,041</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(464,000)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>70,041</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>684,399</b>	<b>24</b> *

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

Facility Name & ID Number GREENWOOD CARE, LTD. # 0031971 Report Period Beginning: 01/01/00 Ending: 12/31/00

---

Balance per General Ledger 614,358

Adjustments:

-

-

-

Total adjustments

-

Balance - Beginning of Year

614,358

Equity(Deficit) from Page 17 Col 1

684,399

Related Party

Equity(Deficit)

-2313102

Income

28327

(2,284,775)

Combined Equity - End of Year

(1,600,376)

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1

Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,272,366	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,272,366	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radic		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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	7,304	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 7,304	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See supplemental schedule	1,669	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,669	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,281,339	30

2

Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	836,496	31
32	Health Care	1,126,424	32
33	General Administration	1,002,135	33
<b>B. Capital Expense</b>			
34	Ownership	702,637	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	79,606	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,747,298	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	534,041	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 534,041	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO 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.

DESCRIPTION	AMOUNT
1 Vending Commissions	1,200
2 Miscellaneous Income - Adjusted out on page 5	469
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
TOTALS	<u><u>1,669</u></u>

Facility Name & ID Number GREENWOOD CARE, LTD.

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	2,025	2,065	\$ 47,564	\$ 23.03	1
2	Assistant Director of Nursing	1,946	2,159	36,267	16.80	2
3	Registered Nurses	53	58	1,250	21.55	3
4	Licensed Practical Nurses	13,144	14,065	227,510	16.18	4
5	Nurse Aides & Orderlies	41,349	42,982	317,106	7.38	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,939	4,804	48,693	10.14	8
9	Activity Director	1,741	1,910	21,852	11.44	9
10	Activity Assistants	17,500	19,061	115,885	6.08	10
11	Social Service Workers	14,195	15,277	178,154	11.66	11
12	Dietician					12
13	Food Service Supervisor	1,683	2,056	25,426	12.37	13
14	Head Cook	5,096	5,430	43,096	7.94	14
15	Cook Helpers/Assistants	9,503	10,154	60,521	5.96	15
16	Dishwashers					16
17	Maintenance Workers	4,251	4,437	34,545	7.79	17
18	Housekeepers	16,975	17,759	115,303	6.49	18
19	Laundry					19
20	Administrator	1,882	2,091	62,009	29.66	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,342	13,192	112,619	8.54	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	2,035	2,237	18,623	8.32	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	149,659	159,737	\$ 1,466,423 *	\$ 9.18	34

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

\*\* See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	monthly \$ 9,600	1-3	35
36	Medical Director	monthly 1,800	9-3	36
37	Medical Records Consultant	96 4,032	10-3	37
38	Nurse Consultant	2,393 28,716	10-3	38
39	Pharmacist Consultant	monthly 960	10-3	39
40	Physical Therapy Consultant	25	10a-3	40
41	Occupational Therapy Consultant	87 4,325	10a-3	41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	300	11-3	44
45	Social Service Consultant			45
46	Other(specify)			46
47	Director of Food Service	14,796	1-3	47
48	Specialized Rehab Consultant	12,876	10a-3	48
49	TOTAL (lines 35 - 48)	2,576 \$ 77,430		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	915 \$ 24,283	10-3	50
51	Licensed Practical Nurses	295 6,183	10-3	51
52	Nurse Aides			52
53	TOTAL (lines 50 - 52)	1,210 \$ 30,466		53

**SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS**

**B. CONSULTANT SERVICES**

<u># of Hrs. Actually Worked</u>	<u># of Hrs. Paid and Accrued</u>	<u>Reporting Period Total Salaries, Wages</u>	<u>Average Hourly Wage</u>
		\$	\$
<u>0</u>	<u>0</u>	\$ <u>0</u>	\$ <u>#DIV/0!</u>



**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	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Painting & Decorating	1994	\$ 5,378	3	\$ 896	\$	\$	\$	\$	\$	\$	\$
2	Painting & Decorating	1995	3,678	3	1,225	612						
3	Painting & Decorating	1996	11,601	3	3,867	3,867	1,934					
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$ 20,657		\$ 5,988	\$ 4,479	\$ 1,934	\$	\$	\$	\$	\$

Facility Name &amp; ID Number GREENWOOD CARE, LTD.

# 0031971

Report Period Beginning: 01/01/00

Ending: 12/31/00

## 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. Illinois Council on Long Term Care-4858
- (3) Did the nursing home make political contributions or payments to a political 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? \_\_\_\_\_
- (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? 10YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line \_\_\_\_\_
- (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. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? YES \_\_\_\_\_ NO X
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 79,605  
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 of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 11,913 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (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. \$ \_\_\_\_\_  
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.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees.

Date: 07/17/2000

To: Administrator/Cost Report Preparer

From: Office of Health Finance

Re: 2000 Long Term Care Cost Report and Instructions on Diskette  
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to be entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12, do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

**WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.**

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 1/2 by 14 size white paper with an 8 1/2 by 14 image on the paper. To ensure an 8 1/2 by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 1/2 by 11. We cannot accept a report with an 8 1/2 by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

**Notes Applicable only to Lotus users**

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu bar after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use File-Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

**Notes Applicable only to Excel users**

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been sealed you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can go to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/rw