

		FOR BHF USE					

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**2006**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2006)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

**I. IDPH Facility ID Number:** 0031971

**Facility Name:** Greenwood Care

**Address:** 1406 North Chicago Avenue Evanston 60201  
 Number City Zip Code

**County:** Cook

**Telephone Number:** (847) 328-7508 **Fax #** (847) 869-4878

**HFS ID Number:** 363487508001

**Date of Initial License for Current Owners:** 01/01/90

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** Steve Lavenda **Telephone Number:** (847) 236 - 1111

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

**Officer or Administrator of Provider**

(Signed) \_\_\_\_\_ (Date) \_\_\_\_\_

(Type or Print Name) \_\_\_\_\_

(Title) \_\_\_\_\_

**Paid Preparer**

(Signed) \_\_\_\_\_ (Date) \_\_\_\_\_

(Print Name and Title) Cary C. Buxbaum, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.  
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE  
 ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES  
 201 S. Grand Avenue East  
 Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care

# 0031971 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	52,925	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	145	TOTALS	145	52,925	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF	47,950	825		48,775
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	47,950	825		48,775

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.16%

D. How many bed-hold days during this year were paid by the Department?

1,877 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

N/A

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 2/1/87

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 2/1/87 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: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/06 Ending: 12/31/06

**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>A. General Services</b>											
1	Dietary	152,414	17,889	25,447	195,750		195,750	(13,315)	182,435			1
2	Food Purchase		197,180		197,180	(15,713)	181,467	(33)	181,434			2
3	Housekeeping	156,235	33,197		189,432		189,432	101	189,533			3
4	Laundry		10,568	9,368	19,936		19,936		19,936			4
5	Heat and Other Utilities			127,417	127,417		127,417	1,935	129,352			5
6	Maintenance	48,655	25,921	103,136	177,712		177,712	(23,942)	153,770			6
7	Other (specify):*							4,310	4,310			7
8	<b>TOTAL General Services</b>	<b>357,304</b>	<b>284,755</b>	<b>265,368</b>	<b>907,427</b>	<b>(15,713)</b>	<b>891,714</b>	<b>(30,944)</b>	<b>860,770</b>			<b>8</b>
	<b>B. Health Care and Programs</b>											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	1,005,451	27,887	35,450	1,068,788		1,068,788	(15,876)	1,052,912			10
10a	Therapy			12,876	12,876		12,876	(4,599)	8,277			10a
11	Activities	129,344	10,952		140,296		140,296		140,296			11
12	Social Services	223,291			223,291		223,291		223,291			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							4,167	4,167			15
16	<b>TOTAL Health Care and Programs</b>	<b>1,358,086</b>	<b>38,839</b>	<b>55,526</b>	<b>1,452,451</b>		<b>1,452,451</b>	<b>(16,308)</b>	<b>1,436,143</b>			<b>16</b>
	<b>C. General Administration</b>											
17	Administrative	72,332		393,549	465,881		465,881	(332,064)	133,817			17
18	Directors Fees											18
19	Professional Services			113,235	113,235		113,235	(81,176)	32,059			19
20	Dues, Fees, Subscriptions & Promotions			37,099	37,099		37,099	(12,230)	24,869			20
21	Clerical & General Office Expenses	145,765	21,647	55,974	223,386		223,386	15,142	238,528			21
22	Employee Benefits & Payroll Taxes			309,833	309,833	15,713	325,546	(1,603)	323,944			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,146	3,146		3,146	291	3,437			24
25	Other Admin. Staff Transportation			2,570	2,570		2,570	2,391	4,961			25
26	Insurance-Prop.Liab.Malpractice			108,189	108,189		108,189	(477)	107,712			26
27	Other (specify):*							25,967	25,967			27
28	<b>TOTAL General Administration</b>	<b>218,097</b>	<b>21,647</b>	<b>1,023,595</b>	<b>1,263,339</b>	<b>15,713</b>	<b>1,279,052</b>	<b>(383,758)</b>	<b>895,295</b>			<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,933,487</b>	<b>345,241</b>	<b>1,344,489</b>	<b>3,623,217</b>		<b>3,623,217</b>	<b>(431,010)</b>	<b>3,192,207</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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care #0031971 Report Period Beginning: 01/01/06 Ending: 12/31/06

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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>D. Ownership</b>											
30	Depreciation			57,074	57,074		57,074	130,476	187,550			30
31	Amortization of Pre-Op. & Org.							(8,459)	(8,459)			31
32	Interest			12,458	12,458		12,458	307,058	319,516			32
33	Real Estate Taxes			122,367	122,367		122,367	5,356	127,723			33
34	Rent-Facility & Grounds			476,280	476,280		476,280	(476,280)				34
35	Rent-Equipment & Vehicles			13,451	13,451		13,451	4,783	18,234			35
36	Other (specify):*							8,459	8,459			36
37	<b>TOTAL Ownership</b>			681,630	681,630		681,630	(28,607)	653,023			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			79,388	79,388		79,388		79,388			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			79,388	79,388		79,388		79,388			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,933,487	345,241	2,105,507	4,384,235		4,384,235	(459,617)	3,924,618			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	51,735	30		9
10	Interest and Other Investment Income	(9,591)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(33)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(7,635)	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	(22,643)	21		24
25	Fund Raising, Advertising and Promotional	(3,152)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,619)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(26,878)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (23,816)		\$	30

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	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(435,800)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (435,800)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (459,617)		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	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	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

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

ID# 0031971  
 Report Period Beginning: 01/01/06  
 Ending: 12/31/06

Sch. V Line

NON-ALLOWABLE EXPENSES		
	Amount	Reference
1	Misc. Income	21
2	Theft & Damage	21
3	Non-allowable Legal	19
4	Building Company Ammortization	31
5	Capitalized R&M	00
6	CCPI Fees	20
7	Building Company Replacement Tax	21
8	Insurance Expense	26
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101	Total	(26,878)

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06

Ending:

12/31/06

## 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					(9,427)	(3,888)						(13,315)	1
2	Food Purchase	(33)											(33)	2
3	Housekeeping			617					(516)				101	3
4	Laundry													4
5	Heat and Other Utilities			816	1,119								1,935	5
6	Maintenance	(10,679)		734	(6,948)	59	(7,108)						(23,942)	6
7	Other (specify):*				747	1,019	2,544						4,310	7
8	<b>TOTAL General Services</b>	<b>(10,712)</b>		<b>2,167</b>	<b>(5,082)</b>	<b>(8,349)</b>	<b>(8,452)</b>		<b>(516)</b>				<b>(30,944)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records				(14,221)				(1,655)				(15,876)	10
10a	Therapy						(4,599)						(4,599)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				2,596		1,571						4,167	15
16	<b>TOTAL Health Care and Programs</b>				<b>(11,625)</b>		<b>(3,028)</b>		<b>(1,655)</b>				<b>(16,308)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			13,431	(42,679)	(287,216)	(15,600)						(332,064)	17
18	Directors Fees													18
19	Professional Services	(913)		(80,485)	208	11,762	(11,748)						(81,176)	19
20	Fees, Subscriptions & Promotions	(12,757)		216	311								(12,230)	20
21	Clerical & General Office Expenses	(31,827)	298	46,703	(267)	236							15,142	21
22	Employee Benefits & Payroll Taxes							(1,603)					(1,603)	22
23	Inservice Training & Education													23
24	Travel and Seminar			73	218								291	24
25	Other Admin. Staff Transportation			466	1,925								2,391	25
26	Insurance-Prop.Liab.Malpractice	(1,292)		257	410	148							(477)	26
27	Other (specify):*			8,431	3,565	13,971							25,967	27
28	<b>TOTAL General Administration</b>	<b>(46,789)</b>	<b>298</b>	<b>(10,908)</b>	<b>(36,309)</b>	<b>(261,099)</b>	<b>(27,348)</b>	<b>(1,603)</b>					<b>(383,758)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(57,501)</b>	<b>298</b>	<b>(8,741)</b>	<b>(53,016)</b>	<b>(269,448)</b>	<b>(38,828)</b>	<b>(1,603)</b>	<b>(2,171)</b>				<b>(431,010)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06 Ending:

12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	51,735	75,776	1,320	1,645								130,476	30
31	Amortization of Pre-Op. & Org.	(8,459)											(8,459)	31
32	Interest	(9,591)	316,698	(422)	373								307,058	32
33	Real Estate Taxes			1,897	3,459								5,356	33
34	Rent-Facility & Grounds		(476,280)										(476,280)	34
35	Rent-Equipment & Vehicles			1,619	1,609	1,555							4,783	35
36	Other (specify):*		8,459										8,459	36
37	<b>TOTAL Ownership</b>	<b>33,685</b>	<b>(75,347)</b>	<b>4,414</b>	<b>7,086</b>	<b>1,555</b>							<b>(28,607)</b>	<b>37</b>
	<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													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>													<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(23,816)</b>	<b>(75,049)</b>	<b>(4,327)</b>	<b>(45,930)</b>	<b>(267,892)</b>	<b>(38,828)</b>	<b>(1,603)</b>	<b>(2,171)</b>				<b>(459,617)</b>	<b>45</b>

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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 Attached		See Attached				
				Greenwood Care LLC	Evanston	Building Company

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 476,280	Greenwood Care, LLC	100.00%	\$	\$ (476,280)	1
2	V	36 Amortization of Loan Fees		Greenwood Care, LLC	%	8,459	8,459	2
3	V	30 Depreciation		Greenwood Care, LLC		72,193	72,193	3
4	V	30 Depreciation - Sec 754		Greenwood Care, LLC		3,583	3,583	4
5	V	32 Mortgage Interest		Greenwood Care, LLC		318,362	318,362	5
6	V	21 Office Expense		Greenwood Care, LLC		288	288	6
7	V	21 Replacement Tax		Greenwood Care, LLC		10	10	7
8	V	32 Interest Income	1,664	Greenwood Care, LLC			(1,664)	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 477,944			\$ 402,895	\$ * (75,049)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care# 0031971Report Period Beginning: 01/01/06Ending: 12/31/06

## 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	3 HOUSEKEEPING	\$	PREFERRED BOOKKEEPING	100.00%	\$ 617	617	15
16	V	5 UTILITIES		PREFERRED BOOKKEEPING	100.00%	816	816	16
17	V	6 REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	734	734	17
18	V	17 ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	13,431	13,431	18
19	V	19 PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	875	875	19
20	V	20 DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	216	216	20
21	V	21 CLERICAL		PREFERRED BOOKKEEPING	100.00%	46,703	46,703	21
22	V	24 SEMINARS		PREFERRED BOOKKEEPING	100.00%	73	73	22
23	V	25 ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	466	466	23
24	V	26 INSURANCE		PREFERRED BOOKKEEPING	100.00%	257	257	24
25	V	27 EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	8,431	8,431	25
26	V	30 DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	1,320	1,320	26
27	V	32 INTEREST		PREFERRED BOOKKEEPING	100.00%	(422)	(422)	27
28	V	33 REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	1,897	1,897	28
29	V	35 EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	1,619	1,619	29
30	V							30
31	V							31
32	V	19 ACCOUNT./BOOKKEEPING	81,360	PREFERRED BOOKKEEPING	100.00%		(81,360)	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	Total		\$ 84,840			\$ 80,513	\$ * (4,327)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care# 0031971Report Period Beginning: 01/01/06Ending: 12/31/06

## 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	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5 UTILITIES	\$	S.I.R. MANAGEMENT, INC.	100.00%	\$ 1,119	1,119	15
16	V	6 REPAIRS AND MAINT.	13,056	S.I.R. MANAGEMENT, INC.	100.00%	6,108	(6,948)	16
17	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	747	747	17
18	V	10 NURSING	28,716	S.I.R. MANAGEMENT, INC.	100.00%	14,495	(14,221)	18
19	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	2,596	2,596	19
20	V	17 ADMINISTRATIVE	50,868	S.I.R. MANAGEMENT, INC.	100.00%	8,189	(42,679)	20
21	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	208	208	21
22	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	311	311	22
23	V	21 CLERICAL & GENERAL	14,796	S.I.R. MANAGEMENT, INC.	100.00%	14,529	(267)	23
24	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	218	218	24
25	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	1,925	1,925	25
26	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	410	410	26
27	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	3,565	3,565	27
28	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	1,645	1,645	28
29	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	373	373	29
30	V	33 REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	3,459	3,459	30
31	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	1,609	1,609	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 107,436			\$ 61,506	\$ * (45,930)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care# 0031971Report Period Beginning: 01/01/06Ending: 12/31/06

## 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%	\$ 5,369	(9,427)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,019	1,019	16
17	V	17	ADMIN./LEGAL SALARIES	326,956	S.I.R. MANAGEMENT, INC.	100.00%	35,811	(291,145)	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	11,762	11,762	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	5,903	5,903	19
20	V								20
21	V	17	ADMIN. SALARY-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	2,381	2,381	21
22	V	6	REPAIRS & MAINT.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	59	59	22
23	V	21	CLERICAL & GEN.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	177	177	23
24	V	26	AUTO INSURANCE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	52	52	24
25	V	27	EMP. BENEFITS-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	4,074	4,074	25
26	V	35	AUTO LEASE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	824	824	26
27	V								27
28	V	17	ADMIN. SALARY-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	1,548	1,548	28
29	V	21	CLERICAL & GEN.-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	59	59	29
30	V	26	AUTO INSURANCE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	96	96	30
31	V	27	EMP. BENEFITS-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	3,994	3,994	31
32	V	35	AUTO LEASE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	731	731	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 341,752				\$ 73,860	\$ * (267,892)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	10A SPECIAL REHAB	12,876	S.I.R. MANAGEMENT, INC.	100.00%	8,277	\$	(4,599)	15
16	V	15 EMP. BEN.-H. CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	1,571		1,571	16
17	V								17
18	V	6 REPAIRS AND MAINT.	18,000	S.I.R. MANAGEMENT, INC.	100.00%	10,892		(7,108)	18
19	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	2,067		2,067	19
20	V								20
21	V								21
22	V	1 DIETICIAN SALARIES	6,400	S.I.R. MANAGEMENT, INC.	100.00%	2,512		(3,888)	22
23	V	7 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	477		477	23
24	V								24
25	V	19 LEGAL FEES	11,748	S.I.R. MANAGEMENT, INC.	100.00%			(11,748)	25
26	V								26
27	V	17 COUNCIL DUES	15,600	S.I.R. MANAGEMENT, INC.	100.00%			(15,600)	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		\$ 64,624			\$ 25,796	\$ *	(38,828)	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	22	EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 79,177	\$ 79,177	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	80,780	CCS EMPLOYEE BENEFIT GROUP	100.00%		(80,780)	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			\$ 80,780			\$ 79,177	\$ * (1,603)	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	01 Dietary	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	03 Housekeeping	6,360	Xcel Supply, LLC	100.00%	5,845	(516)	16
17	V	04 Laundry		Xcel Supply, LLC	100.00%			17
18	V	06 Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10 Nursing	20,412	Xcel Supply, LLC	100.00%	18,757	(1,655)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service		Xcel Supply, LLC	100.00%			21
22	V	20 Dues, Fees, Subscriptions & Promotions		Xcel Supply, LLC	100.00%			22
23	V	21 Clerical & General Office		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits		Xcel Supply, LLC	100.00%			24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary		Xcel Supply, LLC	100.00%			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		\$ 26,773			\$ 24,601	\$ * (2,171)	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			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/06 Ending: 12/31/06

## 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	Bryan Barrish	Shareholder	Administrative	4.83%	See Attached	3.14	7.85%	Alloc. Salary	\$ 2,381	17-7	1
2	Mike Giannini	Shareholder	Administrative	3.45%	See Attached	4.71	11.78%	Alloc. Salary	1,548	17-7	2
3	Eric Rothner	Shareholder	Administrative	51.72%	See Attached	0.53	1.15%	Alloc. Salary	7,481	17-7	3
4	Nenita Guzman	Relative	Dietary	0.00%	See Attached	3.92	7.84%	Alloc. Salary	5,369	1-7	4
5	Louise Bergthold	Shareholder	Administrative	3.45%	See Attached	4.31	7.84%	Alloc. Salary	12,940	17-7	5
6	Tom Winter	Shareholder	Administrative	4.14%	See Attached	4.88	8.13%	Alloc. Salary	13,431	17-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 43,150		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06

Ending: 12/31/06

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06

Ending: 12/31/06

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

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

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

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	3	HOUSEKEEPING	BOOK./ACCNT.INCOME 999,524	10	\$ 7,576	\$	81,360	\$ 617	1
2	5	UTILITIES	BOOK./ACCNT.INCOME 999,524	10	10,021		81,360	816	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME 999,524	10	9,017		81,360	734	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME 999,524	10	165,000	165,000	81,360	13,431	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME 999,524	10	10,747		81,360	875	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME 999,524	10	2,655		81,360	216	6
7	21	CLERICAL	BOOK./ACCNT.INCOME 999,524	10	573,753	512,109	81,360	46,703	7
8	24	SEMINARS	BOOK./ACCNT.INCOME 999,524	10	898		81,360	73	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME 999,524	10	5,727		81,360	466	9
10	26	INSURANCE	BOOK./ACCNT.INCOME 999,524	10	3,157		81,360	257	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME 999,524	10	103,576		81,360	8,431	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME 999,524	10	16,212		81,360	1,320	12
13	32	INTEREST	BOOK./ACCNT.INCOME 999,524	10	(5,190)		81,360	(422)	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME 999,524	10	23,306		81,360	1,897	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME 999,524	10	19,888		81,360	1,619	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				\$ 946,343	\$ 677,109		\$ 80,513	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06

Ending: 12/31/06

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

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

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

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	5	UTILITIES	PATIENT DAYS	621,946	10	\$ 14,269	\$ 48,775	\$ 1,119	1	
2	6	REPAIRS AND MAINT.	PATIENT DAYS	621,946	10	77,891	51,158	48,775	6,108	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	621,946	10	9,520	48,775	747	48,775	3
4	10	NURSING	PATIENT DAYS	621,946	10	184,832	184,832	48,775	14,495	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	621,946	10	33,100	48,775	2,596	48,775	5
6	17	ADMINISTRATIVE	PATIENT DAYS	621,946	10	104,417	104,417	48,775	8,189	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	621,946	10	2,646	48,775	208	48,775	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	621,946	10	3,970	48,775	311	48,775	8
9	21	CLERICAL & GENERAL	PATIENT DAYS/DIRECT	621,946	10	163,095	125,172	48,775	14,529	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	621,946	10	2,778	48,775	218	48,775	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	621,946	10	24,542	48,775	1,925	48,775	11
12	26	INSURANCE	PATIENT DAYS	621,946	10	5,228	48,775	410	48,775	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS/DIRECT	621,946	10	41,464	48,775	3,565	48,775	13
14	30	DEPRECIATION	PATIENT DAYS	621,946	10	20,978	48,775	1,645	48,775	14
15	32	INTEREST	PATIENT DAYS	621,946	10	4,752	48,775	373	48,775	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	621,946	10	44,103	48,775	3,459	48,775	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	621,946	10	20,518	48,775	1,609	48,775	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 758,103	\$ 465,579	\$ 61,506		25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06

Ending: 12/31/06

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

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

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

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	621,946	10	\$ 68,465	\$ 48,775	\$ 5,369	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	621,946	10	12,992	48,775	1,019	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	621,946	10	456,644	48,775	35,811	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	621,946	10	149,980	48,775	11,762	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	621,946	10	75,273	48,775	5,903	5
6									6
7	17	ADMIN. SALARY-B. BARRISH	AVG HRS WKD	20	4	15,163	15,163	2,381	7
8	6	REPAIRS & MAINT.-B. BARRIS	AVG HRS WKD	20	4	376	3	59	8
9	21	CLERICAL & GEN.-B. BARRIS	AVG HRS WKD	20	4	1,125	3	177	9
10	26	AUTO INSURANCE-B. BARRIS	AVG HRS WKD	20	4	330	3	52	10
11	27	EMP. BENEFITS-B. BARRISH	AVG HRS WKD	20	4	25,952	3	4,074	11
12	35	AUTO LEASE-B. BARRISH	AVG HRS WKD	20	4	5,250	3	824	12
13									13
14	17	ADMIN. SALARY-M. GIANNINI	AVG HRS WKD	30	4	9,863	9,863	1,548	14
15	21	CLERICAL & GEN.-M. GIANNI	AVG HRS WKD	30	4	375	5	59	15
16	26	AUTO INSURANCE-M. GIANNI	AVG HRS WKD	30	4	614	5	96	16
17	27	EMP. BENEFITS-M. GIANNINI	AVG HRS WKD	30	4	25,440	5	3,994	17
18	35	AUTO LEASE-M. GIANNINI	AVG HRS WKD	30	4	4,656	5	731	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 852,498	\$ 550,135	\$ 73,860	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06

Ending: 12/31/06

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	10A	SPECIAL REHAB	SPECIAL REHAB INC.	107,736	7	\$ 69,259	\$ 69,259	12,876	\$ 8,277	1
2	15	EMP. BEN.-H. CARE & PROG.	SPECIAL REHAB INC.	107,736	7	13,143		12,876	1,571	2
3										3
4	6	REPAIRS AND MAINT.	MAINTENANCE INC.	126,720	10	76,680	76,680	18,000	10,892	4
5	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	126,720	10	14,551		18,000	2,067	5
6										6
7										7
8	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	83,600	10	32,808	32,808	6,400	2,512	8
9	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	83,600	10	6,226		6,400	477	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					\$ 212,667	\$ 178,747		\$ 25,796	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CCS EMPLOYEE BENEFITS GROUP, INC.  
 Street Address 2201 W. MAIN ST.  
 City / State / Zip Code EVANSTON, IL 60202  
 Phone Number ( 847)905-4000  
 Fax Number ( 847)905-4040

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	<u>22</u>	<u>EMPLOYEE HEALTH INSURANCE</u>	<u>DIRECT ALLOCATION</u>		\$	\$		\$ <u>79,177</u>	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>				\$	\$		\$ <u>79,177</u>	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	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	01	Dietary	Direct Allocation		\$	\$		\$	1
2	03	Housekeeping	Direct Allocation					5,845	2
3	04	Laundry	Direct Allocation						3
4	06	Repairs & Maintenance	Direct Allocation						4
5	10	Nursing	Direct Allocation					18,757	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees, Subscriptions & Prom	Direct Allocation						8
9	21	Clerical & General Office	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation						10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation						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				\$	\$		\$ 24,601	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care

# 0031971 Report Period Beginning: 01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Pacific Life		X	Mortgage	\$35,561.55	03/01/95	\$	\$ 3,560,631	02/01/21	8.6900	\$ 318,362	1								
2												2								
3												3								
4												4								
5	See Supplemental Schedule											5								
<b>Working Capital</b>																				
6	Lake Forest Bank		X	Working Capital				293,369			12,458	6								
7	SIR MGMT		X	Line of Credit				340,000				7								
8	See Supplemental Schedule										(49)	8								
9	TOTAL Facility Related				\$35,561.55		\$	\$ 4,194,000			\$ 330,771	9								
<b>B. Non-Facility Related*</b>																				
10	Interest Income		X								(9,591)	10								
11	Interest Income -Bldg Co.		X								(1,664)	11								
12												12								
13	See Supplemental Schedule											13								
14	TOTAL Non-Facility Related						\$	\$			(11,255)	14								
15	TOTALS (line 9+line14)						\$	\$ 4,194,000			\$ 319,516	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #           

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

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

	1	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1							\$	\$			\$	1								
2												2								
3												3								
4												4								
5												5								
6												6								
7	<b>TOTAL Long-Term</b>											7								
<b>Working Capital</b>																				
8	<u>Alloc. - Preferred Bookkeeping</u>		X				\$	\$			\$ (422)	8								
9	<u>Alloc. - S.I.R. Management</u>		X								373	9								
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Working Capital</b>										(49)	14								
<b>B. Non-Facility Related*</b>																				
15							\$	\$			\$	15								
16												16								
17												17								
18												18								
19												19								
20	<b>TOTAL Non-Facility Related</b>											20								

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

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

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

**B. Real Estate Taxes**

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																																				
1. Real Estate Tax accrual used on 2005 report.		\$ <b>120,000</b>	<b>1</b>																																	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ <b>124,723</b>	<b>2</b>																																	
3. Under or (over) accrual (line 2 minus line 1).		\$ <b>4,723</b>	<b>3</b>																																	
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ <b>123,000</b>	<b>4</b>																																	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<b>5</b>																																	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	<b>6</b>																																	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ <b>127,723</b>	<b>7</b>																																	
Real Estate Tax History:																																				
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2001</td><td><b>119,340</b></td><td><b>8</b></td></tr> <tr><td>2002</td><td><b>121,326</b></td><td><b>9</b></td></tr> <tr><td>2003</td><td><b>124,779</b></td><td><b>10</b></td></tr> <tr><td>2004</td><td><b>116,382</b></td><td><b>11</b></td></tr> <tr><td>2005</td><td><b>119,367</b></td><td><b>12</b></td></tr> </table>	2001	<b>119,340</b>	<b>8</b>	2002	<b>121,326</b>	<b>9</b>	2003	<b>124,779</b>	<b>10</b>	2004	<b>116,382</b>	<b>11</b>	2005	<b>119,367</b>	<b>12</b>	<table border="1"> <tr><td colspan="2"><b>FOR BHF USE ONLY</b></td><td></td></tr> <tr><td><b>13</b></td><td>FROM R. E. TAX STATEMENT FOR 2005</td><td>\$</td><td><b>13</b></td></tr> <tr><td><b>14</b></td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td><b>14</b></td></tr> <tr><td><b>15</b></td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td><b>15</b></td></tr> <tr><td><b>16</b></td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td><b>16</b></td></tr> </table>	<b>FOR BHF USE ONLY</b>			<b>13</b>	FROM R. E. TAX STATEMENT FOR 2005	\$	<b>13</b>	<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>	<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>
2001	<b>119,340</b>	<b>8</b>																																		
2002	<b>121,326</b>	<b>9</b>																																		
2003	<b>124,779</b>	<b>10</b>																																		
2004	<b>116,382</b>	<b>11</b>																																		
2005	<b>119,367</b>	<b>12</b>																																		
<b>FOR BHF USE ONLY</b>																																				
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2005	\$	<b>13</b>																																	
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>																																	
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>																																	
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>																																	
<b>2005 Accrual = 119367*1.03=123000</b>																																				

**NOTES:**

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

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Greenwood Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0031971

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>11-18-324-019-000</u>	<u>Long Term Care Property</u>	\$ <u>119,366.84</u>	\$ <u>119,366.84</u>
2. <u>See Attached</u>	<u>See Attached</u>	\$ <u>89,494.10</u>	\$ <u>5,024.27</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>208,860.94</u>	\$ <u>124,391.11</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

**IMPORTANT NOTICE**

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

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

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

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

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Greenwood Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0031971

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

**A. Summary of Real Estate Tax Cost**

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

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

Facility Name & ID Number Greenwood Care

# 0031971 Report Period Beginning:

01/01/06 Ending:

12/31/06

**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, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: (8,459) 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility- Greenwood Care LLC</u>		<u>1987</u>	<u>\$ 152,555</u>	1
2					2
3	<b>TOTALS</b>			<b>\$ 152,555</b>	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9	Various			1984	2,672		20	76	76	1,573	9
10	Various			1987	24,869		20	723	723	14,953	10
11	Various			1988	27,733		20	1,146	1,146	16,583	11
12	Various			1989	7,668		20	319	319	4,513	12
13	Various			1990	9,800		20	490	490	7,426	13
14	Various			1992	25,025		20	1,244	1,244	18,763	14
15	Various			1993	63,911		20	3,195	3,195	43,943	15
16	Various			1994	20,319		20	1,017	1,017	12,589	16
17	Various			1995	73,839		20	3,693	3,693	42,800	17
18	Various			1996	109,220		20	5,461	5,461	57,622	18
19	Various			1997	73,171		20	3,658	3,658	34,778	19
20	Various			1998	58,371		20	2,919	2,919	24,747	20
21	Various			1999	192,299		20	9,617	9,617	68,963	21
22	Various			2000	171,876		20	8,594	8,594	57,654	22
23	Various			2001	43,730		20	2,186	2,186	12,787	23
24	Various			2002	87,606		20	5,331	5,331	23,955	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		1,845,500	75,776		90,024	14,248	271,751	67
68		65,601	2,234		2,578	344	29,791	68
69			57,074			(57,074)		69
70		\$ 2,903,210	\$ 135,084		\$ 142,271	\$ 7,187	\$ 745,191	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 2,903,210	\$ 135,084		\$ 142,271	\$ 7,187	\$ 745,191	1
2	Hood Exhaust	2003	3,264		20	326	326	1,142	2
3	Mixing Valve	2003	2,354		20	118	118	451	3
4	Fire Door	2003	3,905		20	195	195	635	4
5	Bathroom Work	2003	6,300		20	630	630	1,943	5
6	Bathroom Work	2003	2,250		20	225	225	694	6
7	Elevator Work	2003	4,400		20	220	220	697	7
8	Boiler Work	2003	10,800		20	540	540	1,710	8
9	Boiler Work	2003	4,132		20	207	207	671	9
10	Alarm Work	2003	1,043		20	52	52	161	10
11	Floor & Tile	2003	4,385		20	439	439	1,425	11
12	Drain Pipe	2003	640		20	64	64	213	12
13	Motor & Pump	2003	1,493		20	149	149	473	13
14	Drain Pipe	2003	1,765		20	177	177	574	14
15	Paint	2003	1,759		20	176	176	572	15
16	Tile	2003	1,491		20	149	149	534	16
17	Tile	2003	588		20	59	59	206	17
18	Architect Fees	2003	1,040		20	104	104	416	18
19	Tub Room Work	2003	7,500		20	375	375	1,156	19
20	New Windows	2004	2,100		20	105	105	315	20
21	Fire Door	2004	2,350		20	235	235	705	21
22	Tub Room Work	2004	10,500		20	525	525	1,531	22
23	Water Feeder	2004	1,376		20	138	138	390	23
24	Pump	2004	1,654		20	165	165	469	24
25	Hot Water Heater	2004	2,652		20	133	133	354	25
26	Hot Water Heater	2004	518		20	26	26	69	26
27	Painting	2004	10,392		20	520	520	1,342	27
28	Bathroom Tile Floor	2004	8,448		20	422	422	1,056	28
29	Window Treatment	2004	4,042		20	202	202	505	29
30	Handrails	2004	8,890		20	889	889	2,223	30
31	Boiler	2004	2,127		20	106	106	230	31
32	Nurse Call System	2004	1,252		20	63	63	188	32
33	Nurse Call & Phone System	2004	837		20	42	42	126	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,019,457	\$ 135,084		\$ 150,047	\$ 14,963	\$ 768,367	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 3,019,457	\$ 135,084		\$ 150,047	\$ 14,963	\$ 768,367	1
2	Radiator Piping	2004	1,110		20	56	56	162	2
3	Piping	2004	2,260		20	113	113	320	3
4	Window Treatments	2004	3,401		20	170	170	439	4
5	Cove Base	2004	4,997		20	250	250	645	5
6	Tiles	2004	700		20	35	35	90	6
7	Boiler Repair	2004	1,951		20	98	98	211	7
8	Elevator Door Screen	2004	1,300		20	65	65	179	8
9	Elevator Door Edge	2004	1,300		20	65	65	179	9
10	Elevator Generator	2004	2,950		20	148	148	344	10
11	(4) Windows	2005	1,600		20	160	160	240	11
12	Ejector Pump	2005	2,575		20	258	258	365	12
13	Boiler Work	2005	1,951		20	98	98	195	13
14	Boiler Work	2005	2,037		20	102	102	204	14
15	Elevator Work	2005	4,800		20	240	240	460	15
16	Boiler Work	2005	2,495		20	125	125	229	16
17	Fire Door	2005	2,780		20	139	139	209	17
18	Steal Door	2005	2,425		20	243	243	283	18
19	Elevator Generator	2005	6,850		20	343	343	371	19
20	Elevator Motor	2005	3,950		20	198	198	263	20
21	Sprinkler System	2005	3,110		20	156	156	162	21
22	Water Heater	2005	9,075		20	454	454	567	22
23	Repiping	2005	3,000		20	150	150	263	23
24	Alarm System	2005	1,655		20	83	83	138	24
25	Plumbing	2005	1,670		20	84	84	125	25
26	Plumbing	2005	3,650		20	183	183	259	26
27	Elevator Car Sill	2005	1,950		20	98	98	114	27
28	Sprinkler System Plumbing	2005	1,638		20	82	82	157	28
29	Fire Door	2005	1,650		20	165	165	165	29
30	Fire Doors	2006	8,575		20	36	36	36	30
31	Elevator Generator	2006	2,021		20	101	101	101	31
32	Boiler Valve	2006	4,996		20	167	167	167	32
33	Elevator Generator	2006	4,800		20	60	60	60	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,118,679	\$ 135,084		\$ 154,772	\$ 19,688	\$ 776,069	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,118,679	\$ 135,084		\$ 154,772	\$ 19,688	\$ 776,069	1
2	Boiler-Tank	2006	9,500		20	40	40	40	2
3	Tank-Boiler	2006	3,220		20	13	13	13	3
4	Hvac Condensor	2006	1,901		20	79	79	79	4
5	Sprinkler-Nova	2006	200,371		20	5,844	5,844	5,844	5
6	Sprinkler-Olympic	2006	12,000		20	350	350	350	6
7	Sprinkler-Sbs	2006	8,574		20	250	250	250	7
8	Sprinkler-Permit	2006	5,920		20	173	173	173	8
9	Plumbing Work	2006	4,800		20	200	200	200	9
10	Flooring	2006	2,680		20	78	78	78	10
11	Radiator	2006	2,104		20	105	105	105	11
12	Fire Doors	2006	2,450		20	123	123	123	12
13	Privacy Door Repairs	2006	6,125		20	306	306	306	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,378,324	\$ 135,084		\$ 162,333	\$ 27,249	\$ 783,630	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,378,324	\$ 135,084		\$ 162,333	\$ 27,249	\$ 783,630	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,378,324	\$ 135,084		\$ 162,333	\$ 27,249	\$ 783,630	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 3,378,324	\$ 135,084		\$ 162,333	\$ 27,249	\$ 783,630	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
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22									22
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,378,324	\$ 135,084		\$ 162,333	\$ 27,249	\$ 783,630	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 3,378,324	\$ 135,084		\$ 162,333	\$ 27,249	\$ 783,630	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,378,324	\$ 135,084		\$ 162,333	\$ 27,249	\$ 783,630	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,378,324	\$ 135,084		\$ 162,333	\$ 27,249	\$ 783,630	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
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32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,378,324	\$ 135,084		\$ 162,333	\$ 27,249	\$ 783,630	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12H, Carried Forward	\$ 3,378,324	\$ 135,084		\$ 162,333	\$ 27,249	\$ 783,630		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,378,324	\$ 135,084		\$ 162,333	\$ 27,249	\$ 783,630		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12I, Carried Forward	\$ 3,378,324	\$ 135,084		\$ 162,333	\$ 27,249	\$ 783,630		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,378,324	\$ 135,084		\$ 162,333	\$ 27,249	\$ 783,630		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,378,324	\$ 135,084		\$ 162,333	\$ 27,249	\$ 783,630	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
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21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,378,324	\$ 135,084		\$ 162,333	\$ 27,249	\$ 783,630	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,378,324	\$ 135,084		\$ 162,333	\$ 27,249	\$ 783,630	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,378,324	\$ 135,084		\$ 162,333	\$ 27,249	\$ 783,630	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,378,324	\$ 135,084		\$ 162,333	\$ 27,249	\$ 783,630	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,378,324	\$ 135,084		\$ 162,333	\$ 27,249	\$ 783,630	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,378,324	\$ 135,084		\$ 162,333	\$ 27,249	\$ 783,630	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,378,324	\$ 135,084		\$ 162,333	\$ 27,249	\$ 783,630	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,378,324	\$ 135,084		\$ 162,333	\$ 27,249	\$ 783,630	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,378,324	\$ 135,084		\$ 162,333	\$ 27,249	\$ 783,630	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,378,324	\$ 135,084		\$ 162,333	\$ 27,249	\$ 783,630	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,378,324	\$ 135,084		\$ 162,333	\$ 27,249	\$ 783,630	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,378,324	\$ 135,084		\$ 162,333	\$ 27,249	\$ 783,630	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,378,324	\$ 135,084		\$ 162,333	\$ 27,249	\$ 783,630	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	145		1990	1969	\$ 1,845,500	\$ 75,776		\$ 90,024	\$ 14,248	\$ 271,751	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 1,845,500	\$ 75,776		\$ 90,024	\$ 14,248	\$ 271,751	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	SIR - SIR		1993	1993	\$ 20,955	\$ 665	35	\$ 599	\$ (66)	\$ 8,083	4
5	SIR - PREF		1993	1993	11,494	365	35	328	(37)	4,433	5
6											6
7											7
8											8
	Improvement Type**										
9	Preferred Bookkeeping - Allocation			1997	14,354	321	20	718	397	7,040	9
10	Preferred Bookkeeping - Allocation			1999	114	-	20	6	6	43	10
11	Preferred Bookkeeping - Allocation			2000	720	-	20	36	36	231	11
12											
13	S.I.R. Properties - Preferred Bookkeeping - Allocation			2002	46	-	20	2	2	10	13
14	S.I.R. Properties - Preferred Bookkeeping - Allocation			1999	1,456	146	20	73	(73)	546	14
15	S.I.R. Properties - Preferred Bookkeeping - Allocation			1998	696	70	20	35	(35)	296	15
16	S.I.R. Properties - Preferred Bookkeeping - Allocation			1997	43	4	20	2	(2)	23	16
17	S.I.R. Properties - Preferred Bookkeeping - Allocation			1994	109	3	20	5	2	68	17
18	S.I.R. Properties - Preferred Bookkeeping - Allocation			1993	186	1	20	9	8	126	18
19											
20	S.I.R. Properties - S.I.R. Management - Allocation			2002	83	-	20	4	4	19	20
21	S.I.R. Properties - S.I.R. Management - Allocation			1999	2,655	266	20	133	(133)	996	21
22	S.I.R. Properties - S.I.R. Management - Allocation			1998	1,269	127	20	63	(64)	539	22
23	S.I.R. Properties - S.I.R. Management - Allocation			1997	79	8	20	4	(4)	41	23
24	S.I.R. Properties - S.I.R. Management - Allocation			1994	200	5	20	10	5	125	24
25	S.I.R. Properties - S.I.R. Management - Allocation			1993	340	2	20	17	15	230	25
26											
27	S.I.R. Management - Allocation			1993	9,000	251	20	446	195	6,247	27
28	S.I.R. Management - Allocation			1994	28	-	20	-		28	28
29	S.I.R. Management - Allocation			1995	206	-	20	10	10	117	29
30	S.I.R. Management - Allocation			1999	978	-	20	49	49	353	30
31	S.I.R. Management - Allocation			2000	590	-	20	29	29	197	31
32											
33											
34											
35											
36											

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	<b>TOTAL (lines 4 thru 69)</b>	\$	\$		\$	\$	\$	70
		65,601	2,234		2,578	344	29,791	

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	
71	Purchased in Prior Years	\$ 442,817	\$ 619	\$ 24,611	\$ 23,992	10	\$ 353,342	71
72	Current Year Purchases	10,897	113	607	494	10	607	72
73	Fully Depreciated Assets	89,003				10	89,003	73
74								74
75	TOTALS	\$ 542,717	\$ 732	\$ 25,218	\$ 24,486		\$ 442,952	75

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	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,073,596	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 135,816	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 187,551	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 51,735	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,226,582	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES  NO

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

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 11,458 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>Facility</u>	<u>2004 Chevy Van</u>	\$ <u>564.64</u>	\$ <u>6,776</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$ <b>6,776</b>	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)**

<p>1. HAVE YOU TRAINED CNAs 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. <u>CLASSROOM PORTION:</u></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 CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<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 CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
  - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	N/A	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of 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): <a href="#">See Supplemental</a>									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 CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care# 0031971Report Period Beginning: 01/01/06

Ending:

12/31/06**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 4,041	\$ 6,558	1
2	Cash-Patient Deposits	15,980	15,980	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,542,803	1,542,803	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,487	22,487	6
7	Other Prepaid Expenses	2,834	2,834	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	43,611	43,611	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,631,756	\$ 1,634,273	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 Cost	835,656	835,656	15
16	Equipment, at Historical Cost	832,473	1,051,835	16
17	Accumulated Depreciation (book methods)	(906,246)	(2,275,540)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		101,513	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(91,992)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	74,460	98,888	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 836,343	\$ 2,146,977	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,468,099	\$ 3,781,250	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 132,895	\$ 132,895	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,798	20,798	28
29	Short-Term Notes Payable	340,000	340,000	29
30	Accrued Salaries Payable	191,403	191,403	30
31	Accrued Taxes Payable (excluding real estate taxes)	31,768	31,768	31
32	Accrued Real Estate Taxes(Sch.IX-B)	123,000	123,000	32
33	Accrued Interest Payable		18,049	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	5,600	5,600	35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	22,224	22,224	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 867,688	\$ 885,737	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	293,369	293,369	39
40	Mortgage Payable		3,560,631	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 293,369	\$ 3,854,000	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,161,057	\$ 4,739,737	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,307,042	\$ (958,487)	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,468,099	\$ 3,781,250	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,433,240	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,433,240	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	337,802	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(464,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (126,198)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,307,042	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care# 0031971Report Period Beginning: 01/01/06Ending: 12/31/06**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	\$ 4,711,129	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,711,129	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	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<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***	9,591	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 9,591	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	1,317	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,317	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,722,037	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	907,427	31
32	Health Care	1,452,451	32
33	General Administration	1,263,339	33
<b>B. Capital Expense</b>			
34	Ownership	681,630	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	79,388	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,384,235	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	337,802	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 337,802	43

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

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

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

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

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,989	2,086	\$ 62,683	\$ 30.05	1
2	Assistant Director of Nursing	1,925	2,110	51,285	24.31	2
3	Registered Nurses					3
4	Licensed Practical Nurses	13,858	14,667	368,211	25.10	4
5	CNAs & Orderlies	45,163	49,103	510,239	10.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,782	2,069	23,802	11.50	9
10	Activity Assistants	12,431	13,278	105,542	7.95	10
11	Social Service Workers	14,724	15,751	223,291	14.18	11
12	Dietician	1,997	2,086	29,835	14.30	12
13	Food Service Supervisor					13
14	Head Cook	5,446	5,853	48,253	8.24	14
15	Cook Helpers/Assistants	8,962	9,493	74,326	7.83	15
16	Dishwashers					16
17	Maintenance Workers	3,757	4,125	48,655	11.80	17
18	Housekeepers	17,243	18,496	156,235	8.45	18
19	Laundry					19
20	Administrator	1,881	2,086	72,332	34.67	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,008	12,008	145,765	12.14	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,180	1,300	13,033	10.03	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	143,346	154,511	\$ 1,933,487 *	\$ 12.51	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	95.25/Monthly	\$ 10,651	01-03	35
36	Medical Director	Monthly	7,200	09-03	36
37	Medical Records Consultant	Monthly	4,224	10-03	37
38	Nurse Consultant	Monthly	28,716	10-03	38
39	Pharmacist Consultant	Monthly	2,510	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Director of Food Services	Monthly	14,796	01-03	47
48	Specialized Rehab Consultant	Monthly	12,876	10A-03	48
49	TOTAL (lines 35 - 48)		\$ 80,973		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning: 01/01/06

Ending: 12/31/06

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Delvin Rychener</u>	<u>Administrator</u>	<u>0</u>	\$ <u>72,332</u>	<u>Workers' Compensation Insurance</u>	\$ <u>21,848</u>	<u>IDPH License Fee</u>	\$ _____	
				<u>Unemployment Compensation Insurance</u>	<u>33,018</u>	<u>Advertising: Employee Recruitment</u>	<u>1,637</u>	
				<u>FICA Taxes</u>	<u>143,748</u>	<u>Health Care Worker Background Check</u>	<u>2,320</u>	
				<u>Employee Health Insurance</u>	<u>100,246</u>	(Indicate # of checks performed <u>193</u> )		
				<u>Employee Meals</u>	<u>15,713</u>	<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Advertising &amp; Promotion</u>	<u>3,152</u>	
				<u>401k Matching Contributions</u>	<u>7,395</u>	<u>Dues and Subscriptions</u>	<u>8,689</u>	
				<u>Other Employee Benefits</u>	<u>1,974</u>	<u>Licenses and Permits</u>	<u>11,696</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>				<b>TOTAL (agree to Schedule V,</b>			<b>TOTAL (agree to Sch. V,</b>	
<b>(List each licensed administrator separately.)</b>				<b>line 22, col.8)</b>			<b>line 20, col. 8)</b>	
\$ <u>72,332</u>				\$ <u>323,943</u>			\$ <u>24,869</u>	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>SIR Management - Director of Admin. Services</u>			\$ <u>18,276</u>			\$ _____	<u>Out-of-State Travel</u>	\$ _____
<u>SIR Management - Ancillary Admin Charges</u>			<u>32,592</u>					
<u>SIR Management- Fees</u>			<u>15,600</u>					
<u>See Supplemental Schedule</u>			<u>327,081</u>					
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>				<b>TOTAL</b>			<b>Seminar Expense</b>	
<b>(Attach a copy of any management service agreement)</b>							<b>(agree to Sch. V,</b>	
\$ <u>393,549</u>				\$ _____			<b>line 24, col. 8)</b>	
C. Professional Services							<b>TOTAL</b>	
Vendor/Payee	Type	Amount					\$ <u>3,437</u>	
<u>FR&amp;R</u>	<u>Accounting</u>	\$ <u>13,300</u>						
<u>Preferred Bookkeeping</u>	<u>Accounting</u>	<u>30,900</u>						
<u>Unallowable Legal</u>	<u>Legal</u>	<u>913</u>						
<u>SIR Management</u>	<u>Dir of Regulatory Services</u>	<u>11,748</u>						
<u>Preferred Bookkeeping</u>	<u>Computer Support</u>	<u>3,480</u>						
<u>Preferred Bookkeeping</u>	<u>Bookkeeping</u>	<u>50,460</u>						
<u>Personnel Planners</u>	<u>Unemployment Tax Consult</u>	<u>1,114</u>						
<u>LTC Solutions</u>	<u>Computer</u>	<u>1,320</u>						
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>							<b>Entertainment Expense</b>	
<b>(If total legal fees exceed \$5,000, attach copy of invoices.)</b>							<b>(agree to Sch. V,</b>	
\$ <u>113,235</u>							<b>line 24, col. 8)</b>	

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

\*\*See instructions.

Facility Name & ID Number Greenwood Care

Report Period Beginning: 01/01/06 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. See Attached
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,963 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 79,388  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 15,713 Has any meal income been offset against related costs? No 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? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT