

Facility Name & ID Number Greenwood Care

0031971 Report Period Beginning: 01/01/07 Ending: 12/31/07

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	145	Intermediate (ICF)	145	52,925	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	145	TOTALS	145	52,925	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		2 Medicaid Recipient	3 Private Pay	4 Other	
8	SNF				8
9	SNF/PED				9
10	ICF	47,437	805		48,242
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	47,437	805		48,242

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.15%

D. How many bed-hold days during this year were paid by the Department? 1,649 (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 2/1/1987

J. Was the facility purchased or leased after January 1, 1978?
YES Date 2/1/1987 NO

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	161,955	20,497	20,039	202,491		202,491	(9,159)	193,332		1
2	Food Purchase		196,371		196,371	(15,841)	180,530	(33)	180,497		2
3	Housekeeping	167,369	28,661		196,030		196,030	3	196,033		3
4	Laundry		11,105	10,160	21,265		21,265		21,265		4
5	Heat and Other Utilities			134,495	134,495		134,495	2,152	136,647		5
6	Maintenance	47,372	26,829	117,426	191,627		191,627	(20,521)	171,106		6
7	Other (specify):*							6,036	6,036		7
8	TOTAL General Services	376,696	283,463	282,120	942,279	(15,841)	926,438	(21,522)	904,916		8
	B. Health Care and Programs										
9	Medical Director			7,300	7,300		7,300		7,300		9
10	Nursing and Medical Records	1,061,413	31,844	35,703	1,128,960		1,128,960	(17,926)	1,111,034		10
10a	Therapy			12,876	12,876		12,876	(7,753)	5,123		10a
11	Activities	144,300	10,813	812	155,925		155,925		155,925		11
12	Social Services	234,606			234,606		234,606		234,606		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							3,496	3,496		15
16	TOTAL Health Care and Programs	1,440,319	42,657	56,691	1,539,667		1,539,667	(22,183)	1,517,484		16
	C. General Administration										
17	Administrative	78,125		398,386	476,511		476,511	(331,776)	144,735		17
18	Directors Fees										18
19	Professional Services			148,430	148,430	(2,602)	145,828	(106,702)	39,126		19
20	Dues, Fees, Subscriptions & Promotions			36,981	36,981		36,981	(5,617)	31,364		20
21	Clerical & General Office Expenses	146,182	23,691	51,516	221,389		221,389	28,343	249,732		21
22	Employee Benefits & Payroll Taxes			347,078	347,078	15,841	362,919		362,919		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,085	1,085		1,085	232	1,317		24
25	Other Admin. Staff Transportation			2,394	2,394		2,394	3,510	5,904		25
26	Insurance-Prop.Liab.Malpractice			112,975	112,975		112,975	420	113,395		26
27	Other (specify):*							28,606	28,606		27
28	TOTAL General Administration	224,307	23,691	1,098,845	1,346,843	13,239	1,360,082	(382,985)	977,097		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,041,322	349,811	1,437,656	3,828,789	(2,602)	3,826,187	(426,689)	3,399,498		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care #0031971 Report Period Beginning: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			73,913	73,913		73,913	127,109	201,022		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			25,431	25,431		25,431	300,595	326,026		32
33	Real Estate Taxes			125,002	125,002	2,602	127,604	6,051	133,655		33
34	Rent-Facility & Grounds			476,280	476,280		476,280	(476,280)			34
35	Rent-Equipment & Vehicles			6,710	6,710		6,710	5,364	12,074		35
36	Other (specify):*										36
37	TOTAL Ownership			707,336	707,336	2,602	709,938	(37,161)	672,777		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			79,388	79,388		79,388		79,388		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			79,388	79,388		79,388		79,388		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,041,322	349,811	2,224,380	4,615,513		4,615,513	(463,850)	4,151,663		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:

01/01/07

Ending:

12/31/07

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	46,703	30		9
10	Interest and Other Investment Income	(7,758)	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	(2,155)	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	(23,630)	21		24
25	Fund Raising, Advertising and Promotional	(3,508)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,555)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(60,836)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (53,772)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	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)	(410,079)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (410,079)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (463,850)		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	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

ID# 0031971
 Report Period Beginning: 01/01/07
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NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
1 Miscellaneous Income	\$ (17)	21	1
2 Theft & Damage	943	21	2
3 CCPH Fees	(1,756)	20	3
4 Capitalized R&M	(5,260)	06	4
5 Building Company Amortization	(8,499)	86	5
6 Building Company Replacement Tax	(42)	21	6
7 Building Company - Professional Fees	(23,319)	19	7
8 Insurance Expense	479	26	8
9 PPA, S.I.P. Management Legal	(19,625)	19	9
10 Building Company - Office Expense	(255)	21	10
11 Non Allowable Legal	(681)	19	11
12			12
13			13
14			14
15			15
16			16
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18			18
19			19
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96			96
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98			98
99			99
100			100
101 Total	(60,836)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Greenwood Care

0031971

Report Period Beginning:

01/01/07

Ending:

12/31/07

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)	
	A. General Services													
1	Dietary					(9,159)							(9,159)	1
2	Food Purchase	(33)											(33)	2
3	Housekeeping			634					(631)				3	3
4	Laundry													4
5	Heat and Other Utilities			1,004	1,148								2,152	5
6	Maintenance	(5,260)		882	(6,088)		(10,055)						(20,521)	6
7	Other (specify):*				733	1,126	4,177						6,036	7
8	TOTAL General Services	(5,293)		2,520	(4,207)	(8,033)	(5,878)		(631)				(21,522)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				(15,901)				(2,025)				(17,926)	10
10a	Therapy						(7,753)						(7,753)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				2,472		1,024						3,496	15
16	TOTAL Health Care and Programs				(13,429)		(6,729)		(2,025)				(22,183)	16
	C. General Administration													
17	Administrative			14,996	(45,223)	(285,949)	(15,600)						(331,776)	17
18	Directors Fees													18
19	Professional Services	(43,625)	23,319	(86,871)	389	11,834	(11,748)						(106,702)	19
20	Fees, Subscriptions & Promotions	(7,419)		210	1,592								(5,617)	20
21	Clerical & General Office Expenses	(27,442)	297	49,605	5,689	194							28,343	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			20	212								232	24
25	Other Admin. Staff Transportation			740	2,770								3,510	25
26	Insurance-Prop.Liab.Malpractice	(479)		276	420	203							420	26
27	Other (specify):*			9,529	4,477	14,600							28,606	27
28	TOTAL General Administration	(78,965)	23,616	(11,495)	(29,674)	(259,119)	(27,348)						(382,985)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(84,258)	23,616	(8,975)	(47,310)	(267,152)	(39,955)		(2,656)				(426,689)	29

STATE OF ILLINOIS

Facility Name & ID Number Greenwood Care

0031971

Report Period Beginning:

01/01/07

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Summary B

12/31/07

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 TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	46,703	75,775	1,262	3,369								127,109	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(7,758)	306,056	(49)	2,346								300,595	32
33	Real Estate Taxes			2,167	3,884								6,051	33
34	Rent-Facility & Grounds		(476,280)										(476,280)	34
35	Rent-Equipment & Vehicles			1,764	1,393	2,207							5,364	35
36	Other (specify):*	(8,459)	8,459											36
37	TOTAL Ownership	30,486	(85,990)	5,144	10,992	2,207							(37,161)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(53,772)	(62,374)	(3,831)	(36,318)	(264,945)	(39,955)		(2,656)				(463,850)	45

Facility Name & ID Number Greenwood Care

0031971

Report Period Beginning:

01/01/07

Ending:

12/31/07

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		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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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		72,192	72,192	3
4	V	30 Depreciation - Sec 754		Greenwood Care, LLC		3,583	3,583	4
5	V	32 Mortgage Interest		Greenwood Care, LLC		308,420	308,420	5
6	V	21 Office Expense		Greenwood Care, LLC		255	255	6
7	V	19 Professional Fees		Greenwood Care, LLC		23,319	23,319	7
8	V	32 Interest Income	2,364	Greenwood Care, LLC			(2,364)	8
9	V	21 Replacement Tax		Greenwood Care, LLC		42	42	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 478,644			\$ 416,270	\$ * (62,374)	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: 01/01/07Ending: 12/31/07

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%	\$ 634	\$ 634	15
16	V	5 UTILITIES		PREFERRED BOOKKEEPING	100.00%	1,004	1,004	16
17	V	6 REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	882	882	17
18	V	17 ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	14,996	14,996	18
19	V	19 PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	714	714	19
20	V	20 DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	210	210	20
21	V	21 CLERICAL		PREFERRED BOOKKEEPING	100.00%	49,605	49,605	21
22	V	24 SEMINARS		PREFERRED BOOKKEEPING	100.00%	20	20	22
23	V	25 ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	740	740	23
24	V	26 INSURANCE		PREFERRED BOOKKEEPING	100.00%	276	276	24
25	V	27 EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	9,529	9,529	25
26	V	30 DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	1,262	1,262	26
27	V	32 INTEREST		PREFERRED BOOKKEEPING	100.00%	(49)	(49)	27
28	V	33 REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	2,167	2,167	28
29	V	35 EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	1,764	1,764	29
30	V							30
31	V							31
32	V	19 ACCOUNT./BOOKKEEPING	87,585	PREFERRED BOOKKEEPING	100.00%		(87,585)	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		\$ 91,065			\$ 87,234	\$ * (3,831)	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: 01/01/07Ending: 12/31/07

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	5 UTILITIES	\$	S.I.R. MANAGEMENT, INC.	100.00%	\$ 1,148	\$ 1,148	15
16	V	6 REPAIRS AND MAINT.	13,056	S.I.R. MANAGEMENT, INC.	100.00%	6,968	(6,088)	16
17	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	733	733	17
18	V	10 NURSING	28,716	S.I.R. MANAGEMENT, INC.	100.00%	12,815	(15,901)	18
19	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	2,472	2,472	19
20	V	17 ADMINISTRATIVE	53,768	S.I.R. MANAGEMENT, INC.	100.00%	8,545	(45,223)	20
21	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	389	389	21
22	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	1,592	1,592	22
23	V	21 CLERICAL & GENERAL	14,796	S.I.R. MANAGEMENT, INC.	100.00%	20,485	5,689	23
24	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	212	212	24
25	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	2,770	2,770	25
26	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	420	420	26
27	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	4,477	4,477	27
28	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	3,369	3,369	28
29	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	2,346	2,346	29
30	V	33 REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	3,884	3,884	30
31	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	1,393	1,393	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 110,336			\$ 74,018	\$ * (36,318)	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: 01/01/07Ending: 12/31/07

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%	\$ 5,637	\$ (9,159)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,126	1,126	16
17	V	17	ADMIN./LEGAL SALARIES	328,893	S.I.R. MANAGEMENT, INC.	100.00%	39,315	(289,578)	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	11,834	11,834	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	7,925	7,925	19
20	V								20
21	V	17	ADMIN. SALARY-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	2,526	2,526	21
22	V	6	REPAIRS & MAINT.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			22
23	V	21	CLERICAL & GEN.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	145	145	23
24	V	26	AUTO INSURANCE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	94	94	24
25	V	27	EMP. BENEFITS-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	3,381	3,381	25
26	V	35	AUTO LEASE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	1,281	1,281	26
27	V								27
28	V	17	ADMIN. SALARY-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	1,103	1,103	28
29	V	21	CLERICAL & GEN.-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	48	48	29
30	V	26	AUTO INSURANCE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	109	109	30
31	V	27	EMP. BENEFITS-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	3,294	3,294	31
32	V	35	AUTO LEASE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	926	926	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 343,689				\$ 78,744	\$ * (264,945)	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: 01/01/07Ending: 12/31/07

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%	5,123	\$	(7,753)	15
16	V	15 EMP. BEN.-H. CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	1,024		1,024	16
17	V								17
18	V	6 REPAIRS AND MAINT.	30,960	S.I.R. MANAGEMENT, INC.	100.00%	20,905		(10,055)	18
19	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	4,177		4,177	19
20	V								20
21	V	19 LEGAL FEES	11,748					(11,748)	21
22	V	17 COUNCIL DUES	15,600					(15,600)	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		\$ 71,184			\$ 31,229	\$ *	(39,955)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 83,630	\$ 83,630	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	83,630	CCS EMPLOYEE BENEFIT GROUP	100.00%		(83,630)	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			\$ 83,630			\$ 83,630	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	3 Housekeeping	7,823	Xcel Supply, LLC	100.00%	7,192	(631)	16
17	V	4 Laundry		Xcel Supply, LLC	100.00%			17
18	V	6 Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10 Nursing	25,105	Xcel Supply, LLC	100.00%	23,081	(2,025)	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 And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21 Office And Clerical		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		\$ 32,928			\$ 30,273	\$ * (2,656)	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: 01/01/07

Ending: 12/31/07

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: 01/01/07

Ending: 12/31/07

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: 01/01/07 Ending: 12/31/07

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	Owner	Administrative	15.42%	See Attached	2.65	6.63%	Alloc. Salary	\$ 2,526	17-7	1
2	Mike Giannini	Owner	Administrative	3.45%	See Attached	3.41	8.53%	Alloc. Salary	1,103	17-7	2
3	Eric Rothner	Owner	Administrative	51.72%	See Attached	0.55	1.19%	Alloc. Salary	7,655	17-7	3
4	Nenita Guzman	Relative	Dietary	0.00%	See Attached	3.95	7.90%	Alloc. Salary	5,637	1-7	4
5	Louise Bergthold	Owner	Administrative	3.45%	See Attached	4.34	7.89%	Alloc. Salary	14,202	17-7	5
6	Tom Winter	Owner	Administrative	4.14%	See Attached	5	8.33%	Alloc. Salary	14,996	17-7	6
7	Kim Rudolph	Relative	Clerical	0.00%	See Attached	0.45	1.29%	Alloc. Salary	396	17-7	7
8	Adam Vales	Relative	Clerical	0.00%	See Attached	0.52	1.30%	Alloc. Salary	720	17-7	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 47,235		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: 01/01/07

Ending: 12/31/07

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:

01/01/07

Ending: 12/31/07

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 1,051,322	10	\$ 7,611	\$	87,585	\$ 634	1
2	5	UTILITIES	BOOK./ACCNT.INCOME 1,051,322	10	12,056		87,585	1,004	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME 1,051,322	10	10,582		87,585	882	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME 1,051,322	10	180,000	180,000	87,585	14,996	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME 1,051,322	10	8,570		87,585	714	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME 1,051,322	10	2,521		87,585	210	6
7	21	CLERICAL	BOOK./ACCNT.INCOME 1,051,322	10	595,432	519,081	87,585	49,605	7
8	24	SEMINARS	BOOK./ACCNT.INCOME 1,051,322	10	240		87,585	20	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME 1,051,322	10	8,887		87,585	740	9
10	26	INSURANCE	BOOK./ACCNT.INCOME 1,051,322	10	3,314		87,585	276	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME 1,051,322	10	114,384		87,585	9,529	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME 1,051,322	10	15,147		87,585	1,262	12
13	32	INTEREST	BOOK./ACCNT.INCOME 1,051,322	10	(585)		87,585	(49)	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME 1,051,322	10	26,015		87,585	2,167	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME 1,051,322	10	21,168		87,585	1,764	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				\$ 1,005,342	\$ 699,081		\$ 87,234	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care

0031971

Report Period Beginning:

01/01/07

Ending: 12/31/07

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	5	UTILITIES	PATIENT DAYS	611,427	10	\$ 14,547	\$ 48,242	\$ 1,148	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	611,427	10	88,312	48,242	6,968	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	611,427	10	9,289	48,242	733	3
4	10	NURSING	PATIENT DAYS	611,427	10	162,421	48,242	12,815	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	611,427	10	31,333	48,242	2,472	5
6	17	ADMINISTRATIVE	PATIENT DAYS	611,427	10	108,301	48,242	8,545	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	611,427	10	4,925	48,242	389	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	611,427	10	20,178	48,242	1,592	8
9	21	CLERICAL & GENERAL	PATIENT DAYS/DIRECT	611,427	10	259,625	48,242	20,485	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	611,427	10	2,693	48,242	212	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	611,427	10	35,101	48,242	2,770	11
12	26	INSURANCE	PATIENT DAYS	611,427	10	5,328	48,242	420	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS/DIRECT	611,427	10	56,748	48,242	4,477	13
14	30	DEPRECIATION	PATIENT DAYS	611,427	10	42,694	48,242	3,369	14
15	32	INTEREST	PATIENT DAYS	611,427	10	29,739	48,242	2,346	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	611,427	10	49,229	48,242	3,884	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	611,427	10	17,659	48,242	1,393	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 938,122	\$ 526,247	\$ 74,018	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care

0031971

Report Period Beginning:

01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY SALARIES	PATIENT DAYS	611,427	10	\$ 71,444	\$ 71,444	48,242	\$ 5,637	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	611,427	10	14,275	48,242	48,242	1,126	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	611,427	10	498,282	498,282	48,242	39,315	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	611,427	10	149,980	48,242	48,242	11,834	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	611,427	10	100,448	48,242	48,242	7,925	5
6										6
7	17	ADMIN. SALARY-B. BARRISH	AVG HRS WKD	23	10	22,231	22,231	2	2,526	7
8	6	REPAIRS & MAINT.-B. BARRIS	AVG HRS WKD	23	10			2		8
9	21	CLERICAL & GEN.-B. BARRIS	AVG HRS WKD	23	10	1,275		2	145	9
10	26	AUTO INSURANCE-B. BARRIS	AVG HRS WKD	23	10	824		2	94	10
11	27	EMP. BENEFITS-B. BARRISH	AVG HRS WKD	23	10	29,750		2	3,381	11
12	35	AUTO LEASE-B. BARRISH	AVG HRS WKD	23	10	11,272		2	1,281	12
13										13
14	17	ADMIN. SALARY-M. GIANNINI	AVG HRS WKD	30	10	9,702	9,702	3	1,103	14
15	21	CLERICAL & GEN.-M. GIANNI	AVG HRS WKD	30	10	425		3	48	15
16	26	AUTO INSURANCE-M. GIANNI	AVG HRS WKD	30	10	959		3	109	16
17	27	EMP. BENEFITS-M. GIANNINI	AVG HRS WKD	30	10	28,968		3	3,294	17
18	35	AUTO LEASE-M. GIANNINI	AVG HRS WKD	30	10	8,144		3	926	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 947,979	\$ 601,659		\$ 78,744	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care

0031971

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	\$ 42,868	\$ 42,868	12,876	\$ 5,123	1
2	15	EMP. BEN.-H. CARE & PROG.	SPECIAL REHAB INC.	107,736	7	8,566		12,876	1,024	2
3										3
4	6	REPAIRS AND MAINT.	MAINTENANCE INC.	116,640	8	78,758	78,758	30,960	20,905	4
5	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	116,640	8	15,737		30,960	4,177	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					\$ 145,929	\$ 121,626		\$ 31,229	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care

0031971

Report Period Beginning:

01/01/07

Ending: 12/31/07

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 West Main Street
 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	22	EMPLOYEE HEALTH INSURANCE	DIRECT ALLOCATION		\$	\$		\$ 83,630	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	TOTALS				\$	\$		\$ 83,630	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care

0031971

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	1	Dietary	Direct Allocation			\$		\$	1
2	3	Housekeeping	Direct Allocation					7,192	2
3	4	Laundry	Direct Allocation						3
4	6	Repairs & Maintenance	Direct Allocation						4
5	10	Nursing	Direct Allocation					23,081	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	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					\$		\$	30,273

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care

0031971

Report Period Beginning:

01/01/07

Ending:

12/31/07

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:

01/01/07

Ending: 12/31/07

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:

01/01/07

Ending: 12/31/07

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: 01/01/07 Ending: 12/31/07

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Pacific Life		X	Mortgage	\$35,561.55	03/01/95	\$	\$ 3,442,908	02/11/2021	8.6900	\$ 308,420	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	SIR MGMT		X	Line of Credit				465,000			25,431	6
7	Lake Forest Bank		X	Working Capital				81,125				7
8	See Supplemental Schedule							138,172			2,297	8
9	TOTAL Facility Related				\$35,561.55		\$	\$ 4,127,205			\$ 336,148	9
	B. Non-Facility Related*											
10	Interest Income		X								(7,758)	10
11	Interest Income - Bldg Co.		X								(2,364)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						\$	\$			(10,122)	14
15	TOTALS (line 9+line14)						\$	\$ 4,127,205			\$ 326,026	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:

01/01/07

Ending:

12/31/07

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	TOTAL Long-Term									7										
Working Capital																				
8	Short Term Loan Payable					\$	\$ 138,172			\$	8									
9	Alloc. - Preferred Bookkeeping		X							(49)	9									
10	Alloc. - S.I.R. Management		X							2,346	10									
11											11									
12											12									
13											13									
14	TOTAL Working Capital						138,172			2,297	14									
B. Non-Facility Related*																				
15						\$	\$			\$	15									
16											16									
17											17									
18											18									
19											19									
20	TOTAL Non-Facility Related										20									

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

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

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

B. Real Estate Taxes

<p>Important, 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 2006 report.		\$ 123,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 127,453	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 4,453	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 126,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$ 2,602	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$ _____	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 133,655	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	121,326	8
	2003	124,779	9
	2004	116,382	10
	2005	119,367	11
	2006	121,402	12
2006 Accrual = \$121,402 x 1.03 = \$126,600			
Property Appraisal = \$102 + \$2,500			
Alloc. - Preferred Bookkeeping = \$2,167			
Alloc. - S.I.R. Management = \$3,884			
		FOR BHF USE ONLY	
	13	FROM R. E. TAX STATEMENT FOR 2006 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

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. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

Facility Name & ID Number Greenwood Care

0031971 Report Period Beginning:

01/01/07 Ending:

12/31/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,647 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 7

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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
	Improvement Type**										
9	Various			1984	2,672		20	76	76	1,649	9
10	Various			1987	24,869		20	699	699	15,652	10
11	Various			1988	27,733		20	1,146	1,146	17,729	11
12	Various			1989	7,668		20	319	319	4,831	12
13	Various			1990	9,800		20	490	490	7,916	13
14	Various			1992	25,025		20	1,244	1,244	20,008	14
15	Various			1993	63,911		20	3,195	3,195	47,138	15
16	Various			1994	20,319		20	1,017	1,017	13,604	16
17	Various			1995	73,839		20	3,693	3,693	46,493	17
18	Various			1996	109,220		20	5,461	5,461	63,082	18
19	Various			1997	73,171		20	3,658	3,658	38,437	19
20	Various			1998	58,371		20	2,919	2,919	27,664	20
21	Various			1999	192,299		20	9,617	9,617	78,577	21
22	Various			2000	171,876		20	8,594	8,594	66,246	22
23	Various			2001	43,730		20	2,186	2,186	14,972	23
24	Various			2002	87,606		20	5,331	5,331	29,281	24
25	Various			2003	59,109		20	4,205	4,205	17,877	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:

01/01/07

Ending:

12/31/07

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	1,361,775	67
68		71,236	2,675		2,676	1	32,877	68
69			73,913			(73,913)		69
70		\$ 2,967,954	\$ 152,364		\$ 146,550	\$ (5,814)	\$ 1,905,808	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

0031971

Report Period Beginning:

01/01/07

Ending:

12/31/07

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 12A, Carried Forward		\$ 2,967,954	\$ 152,364		\$ 146,550	\$ (5,814)	\$ 1,905,808	1
2	Tub Room Work	2004			20				2
3	New Windows	2004	2,100		20	105	105	420	3
4	Fire Door	2004	2,350		20	235	235	940	4
5	Tub Room Work	2004	10,500		20	525	525	2,056	5
6	Water Feeder	2004	1,376		20	138	138	527	6
7	Pump	2004	1,654		20	165	165	634	7
8	Hot Water Heater	2004			20				8
9	Hot Water Heater	2004	2,652		20	133	133	486	9
10	Hot Water Heater	2004			20				10
11	Hot Water Heater	2004	518		20	26	26	95	11
12	Painting	2004	10,392		20	520	520	1,862	12
13	Bathroom Tile Floor	2004	8,448		20	422	422	1,478	13
14	Window Treatment	2004			20				14
15	Window Treatment	2004	4,042		20	202	202	707	15
16	Handrails	2004	8,890		20	889	889	3,112	16
17	Boiler	2004			20				17
18	Boiler	2004	2,127		20	106	106	337	18
19	Nurse Call System	2004	1,252		20	63	63	250	19
20	Nurse Call & Phone System	2004	837		20	42	42	167	20
21	Radiator Piping	2004	1,110		20	56	56	217	21
22	Piping	2004	2,260		20	113	113	433	22
23	Window Treatments	2004	3,401		20	170	170	609	23
24	Cove Base	2004	4,997		20	250	250	895	24
25	Tiles	2004	700		20	35	35	125	25
26	Plumbing	2004			20				26
27	Tiles	2004			20				27
28	Piping	2004			20				28
29	Boiler Repair	2004	1,951		20	98	98	309	29
30	Plumbing	2004			20				30
31	Air Filtration System	2004			20				31
32	Elevator Door Screen	2004	1,300		20	65	65	244	32
33	Elevator Door Edge	2004	1,300		20	65	65	244	33
34	TOTAL (lines 1 thru 33)		\$ 3,042,111	\$ 152,364		\$ 150,973	\$ (1,391)	\$ 1,921,955	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:

01/01/07

Ending:

12/31/07

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 12B, Carried Forward		\$ 3,042,111	\$ 152,364		\$ 150,973	\$ (1,391)	\$ 1,921,955	1
2	Elevator Generator	2004	2,950		20	148	148	492	2
3	(4) Windows	2005	1,600		20	160	160	400	3
4	Ejector Pump	2005	2,575		20	258	258	622	4
5	Boiler Work	2005	1,951		20	98	98	293	5
6	Boiler Work	2005	2,037		20	102	102	306	6
7	Elevator Work	2005	4,800		20	240	240	700	7
8	Boiler Work	2005			20				8
9	Boiler Work	2005	2,495		20	125	125	353	9
10	Hot Water System	2005			20				10
11	Fire Door	2005	2,780		20	139	139	348	11
12	Fire Door	2005			20				12
13	Water Heater	2005			20				13
14	Steal Door	2005	2,425		20	243	243	525	14
15	Elevator Generator	2005	6,850		20	343	343	714	15
16	Elevator Motor	2005	3,950		20	198	198	461	16
17	Sprinkler System	2005	3,110		20	156	156	317	17
18	Water Heater	2005	9,075		20	454	454	1,021	18
19	Repiping	2005	3,000		20	150	150	413	19
20	Alarm System	2005	1,655		20	83	83	221	20
21	Plumbing	2005	1,670		20	84	84	209	21
22	Plumbing	2005	3,650		20	183	183	441	22
23	Elevator Car Sill	2005	1,950		20	98	98	211	23
24	Sprinkler System Plumbing	2005	1,638		20	82	82	239	24
25	Fire Door	2005	1,650		20	83	83	172	25
26	Fire Doors	2006	8,575		20	429	429	464	26
27	Elevator Generator	2006	2,021		20	101	101	202	27
28	Boiler Valve	2006	4,996		20	250	250	416	28
29	Elevator Generator	2006	4,800		20	240	240	300	29
30	Boiler-Tank	2006	9,500		20	475	475	515	30
31	Tank-Boiler	2006	3,220		20	161	161	174	31
32	Hvac Condensor	2006	1,901		20	95	95	174	32
33	Sprinkler-Nova	2006	200,371		20	10,019	10,019	15,863	33
34	TOTAL (lines 1 thru 33)		\$ 3,339,306	\$ 152,364		\$ 166,170	\$ 13,806	\$ 1,948,521	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:

01/01/07

Ending:

12/31/07

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		\$ 3,339,306	\$ 152,364		\$ 166,170	\$ 13,806	\$ 1,948,521	1
2	Sprinkler-Olympic	2006	12,000		20	600	600	950	2
3	Sprinkler-Sbs	2006	8,574		20	429	429	679	3
4	Sprinkler-Permit	2006	5,920		20	296	296	469	4
5	Plumbing Work	2006	4,800		20	240	240	440	5
6	Flooring	2006	2,680		20	134	134	212	6
7	Radiators	2006	2,104		20	105	105	123	7
8	Fire Doors	2006	2,450		20	123	123	133	8
9	Privacy Fire Door	2006	6,125		20	306	306	357	9
10	Fire Door	2007	2,925		20	268	268	268	10
11	Fire Door	2007	1,725		20	144	144	144	11
12	Sprinkler	2007	126,027		20	4,201	4,201	4,201	12
13	Boiler Work	2007	3,970		20	182	182	182	13
14	Fire Door	2007	1,175		20	69	69	69	14
15	Elevator Generator	2007	8,500		20	425	425	425	15
16	Fire Doors	2007	1,275		20	53	53	53	16
17	Elevator	2007	5,720		20	72	72	72	17
18	Fence	2007	2,700		20	135	135	135	18
19	Bathroom Repairs	2007	2,560		20	128	128	128	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)		\$ 3,540,536	\$ 152,364		\$ 174,080	\$ 21,716	\$ 1,957,561	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,540,536	\$ 152,364		\$ 174,080	\$ 21,716	\$ 1,957,561	1
2									2
3									3
4									4
5									5
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,540,536	\$ 152,364		\$ 174,080	\$ 21,716	\$ 1,957,561	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 3,540,536	\$ 152,364		\$ 174,080	\$ 21,716	\$ 1,957,561	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,540,536	\$ 152,364		\$ 174,080	\$ 21,716	\$ 1,957,561	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 3,540,536	\$ 152,364		\$ 174,080	\$ 21,716	\$ 1,957,561	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,540,536	\$ 152,364		\$ 174,080	\$ 21,716	\$ 1,957,561	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 3,540,536	\$ 152,364		\$ 174,080	\$ 21,716	\$ 1,957,561	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,540,536	\$ 152,364		\$ 174,080	\$ 21,716	\$ 1,957,561	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 3,540,536	\$ 152,364		\$ 174,080	\$ 21,716	\$ 1,957,561	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,540,536	\$ 152,364		\$ 174,080	\$ 21,716	\$ 1,957,561	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 3,540,536	\$ 152,364		\$ 174,080	\$ 21,716	\$ 1,957,561	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,540,536	\$ 152,364		\$ 174,080	\$ 21,716	\$ 1,957,561	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 3,540,536	\$ 152,364		\$ 174,080	\$ 21,716	\$ 1,957,561	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,540,536	\$ 152,364		\$ 174,080	\$ 21,716	\$ 1,957,561	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12K, Carried Forward		\$ 3,540,536	\$ 152,364		\$ 174,080	\$ 21,716	\$ 1,957,561	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,540,536	\$ 152,364		\$ 174,080	\$ 21,716	\$ 1,957,561	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12L, Carried Forward		\$ 3,540,536	\$ 152,364		\$ 174,080	\$ 21,716	\$ 1,957,561	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,540,536	\$ 152,364		\$ 174,080	\$ 21,716	\$ 1,957,561	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12M, Carried Forward		\$ 3,540,536	\$ 152,364		\$ 174,080	\$ 21,716	\$ 1,957,561	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,540,536	\$ 152,364		\$ 174,080	\$ 21,716	\$ 1,957,561	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12N, Carried Forward		\$ 3,540,536	\$ 152,364		\$ 174,080	\$ 21,716	\$ 1,957,561	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,540,536	\$ 152,364		\$ 174,080	\$ 21,716	\$ 1,957,561	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12O, Carried Forward		\$ 3,540,536	\$ 152,364		\$ 174,080	\$ 21,716	\$ 1,957,561	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,540,536	\$ 152,364		\$ 174,080	\$ 21,716	\$ 1,957,561	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12P, Carried Forward		\$ 3,540,536	\$ 152,364		\$ 174,080	\$ 21,716	\$ 1,957,561	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)		\$ 3,540,536	\$ 152,364		\$ 174,080	\$ 21,716	\$ 1,957,561	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:

01/01/07

Ending:

12/31/07

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	\$ 1,361,775	4
5											5
6											6
7											7
8											8
Improvement Type**											
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:

01/01/07

Ending:

12/31/07

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	\$	1,361,775	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

0031971

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	SIR - SIR		1993	1993	\$ 21,083	\$ 669	35	\$ 602	\$ (67)	\$ 8,734	4
5	SIR - Pref		1993	1993	11,764	373	35	336	(37)	4,873	5
6											6
7											7
8											8
	Improvement Type**										
9	Preferred Bookkeeping - Allocation		1997		14,691	329	20	735	406	7,940	9
10	Preferred Bookkeeping - Allocation		1999		117	-	20	6	6	50	10
11	Preferred Bookkeeping - Allocation		2000		737	-	20	37	37	273	11
12											12
13	S.I.R. Properties - Preferred Bookkeeping - Allocation		2007		206	10	20	10		10	13
14	S.I.R. Properties - Preferred Bookkeeping - Allocation		2002		47	-	20	2	2	13	14
15	S.I.R. Properties - Preferred Bookkeeping - Allocation		1999		1,491	149	20	75	(74)	634	15
16	S.I.R. Properties - Preferred Bookkeeping - Allocation		1998		712	71	20	36	(35)	338	16
17	S.I.R. Properties - Preferred Bookkeeping - Allocation		1997		44	2	20	2		25	17
18	S.I.R. Properties - Preferred Bookkeeping - Allocation		1994		112	3	20	6	3	76	18
19	S.I.R. Properties - Preferred Bookkeeping - Allocation		1993		191	1	20	-	(1)	138	19
20											20
21	S.I.R. Properties - S.I.R. Management - Allocation		2007		369	18	20	18		18	21
22	S.I.R. Properties - S.I.R. Management - Allocation		2002		84	-	20	4	4	23	22
23	S.I.R. Properties - S.I.R. Management - Allocation		1999		2,671	267	20	134	(133)	1,135	23
24	S.I.R. Properties - S.I.R. Management - Allocation		1998		1,277	128	20	64	(64)	606	24
25	S.I.R. Properties - S.I.R. Management - Allocation		1997		79	4	20	4		46	25
26	S.I.R. Properties - S.I.R. Management - Allocation		1994		201	5	20	10	5	135	26
27	S.I.R. Properties - S.I.R. Management - Allocation		1993		342	2	20	17	15	248	27
28											28
29	S.I.R. Management - Allocation		1993		9,055	252	20	449	197	6,734	29
30	S.I.R. Management - Allocation		1994		28	-	20	-		28	30
31	S.I.R. Management - Allocation		1995		207	-	20	10	10	128	31
32	S.I.R. Management - Allocation		1999		984	-	20	49	49	404	32
33	S.I.R. Management - Allocation		2000		594	-	20	30	30	228	33
34	S.I.R. Management - Allocation		2007		4,150	392	20	40	(352)	40	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:

01/01/07

Ending:

12/31/07

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)	\$	71,236	\$	2,675	\$	2,676	\$	1	\$	32,877	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 # 0031971 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	\$ 401,430	\$ 516	\$ 23,174	\$ 22,658	10	\$ 324,748	71
72	Current Year Purchases	44,978	1,439	1,647	208	10	1,647	72
73	Fully Depreciated Assets	141,934				10	141,934	73
74								74
75	TOTALS	\$ 588,342	\$ 1,955	\$ 24,821	\$ 22,866		\$ 468,329	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		PASSENGER VAN	2007	\$ 14,137	\$	\$ 2,121	\$ 2,121	5	\$ 2,121	76
77										77
78										78
79										79
80	TOTALS			\$ 14,137	\$	\$ 2,121	\$ 2,121		\$ 2,121	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)	\$ 4,295,570	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 154,319	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 201,022	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 46,703	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,428,011	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	TOTAL				\$			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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 9,867 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Alloc. - S.I.R. Management</u>		\$	\$ <u>2,207</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>2,207</u>	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)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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

Facility Name & ID Number Greenwood Care# 0031971 Report Period Beginning:01/01/07 Ending:12/31/07

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care# 0031971Report Period Beginning: 01/01/07

Ending:

12/31/07**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 13,440	\$ 22,496	1
2	Cash-Patient Deposits	17,576	17,576	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,204,911	1,204,911	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	26,165	26,165	6
7	Other Prepaid Expenses	3,068	3,068	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	10,214	10,214	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,275,374	\$ 1,284,430	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		152,555	13
14	Buildings, at Historical Cost		2,274,062	14
15	Leasehold Improvements, at Historical Cost	961,682	961,682	15
16	Equipment, at Historical Cost	901,939	1,121,301	16
17	Accumulated Depreciation (book methods)	(980,159)	(2,425,228)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		101,213	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(100,451)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	39,365	63,793	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 922,827	\$ 2,148,927	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,198,201	\$ 3,433,357	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 103,617	\$ 103,617	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,158	20,158	28
29	Short-Term Notes Payable	603,172	603,172	29
30	Accrued Salaries Payable	214,235	214,235	30
31	Accrued Taxes Payable (excluding real estate taxes)	27,411	27,411	31
32	Accrued Real Estate Taxes(Sch.IX-B)	126,600	126,600	32
33	Accrued Interest Payable		17,453	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	2,500	2,500	35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	17,261	17,261	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,114,954	\$ 1,132,407	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	81,125	81,125	39
40	Mortgage Payable		3,442,908	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 81,125	\$ 3,524,033	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,196,079	\$ 4,656,440	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,002,122	\$ (1,223,083)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,198,201	\$ 3,433,357	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,307,046	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,307,046	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	130,076	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	(435,000)	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)	\$ (304,924)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,002,122	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care# 0031971Report Period Beginning: 01/01/07Ending: 12/31/07**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,736,614	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,736,614	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	7,758	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,758	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	1,217	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,217	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,745,589	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	942,279	31
32	Health Care	1,539,667	32
33	General Administration	1,346,843	33
B. Capital Expense			
34	Ownership	707,336	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	79,388	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,615,513	40
41	Income before Income Taxes (line 30 minus line 40)**	130,076	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 130,076	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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:

01/01/07

Ending:

12/31/07

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	1,797	2,086	\$ 64,784	\$ 31.06	1
2	Assistant Director of Nursing	1,925	2,086	50,734	24.32	2
3	Registered Nurses					3
4	Licensed Practical Nurses	14,199	14,932	383,803	25.70	4
5	CNAs & Orderlies	46,773	51,625	549,309	10.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,331	1,436	17,943	12.50	9
10	Activity Assistants	13,831	14,524	126,357	8.70	10
11	Social Service Workers	14,915	16,947	234,606	13.84	11
12	Dietician	2,037	2,086	30,897	14.81	12
13	Food Service Supervisor					13
14	Head Cook	5,242	5,632	48,193	8.56	14
15	Cook Helpers/Assistants	9,335	9,542	82,865	8.68	15
16	Dishwashers					16
17	Maintenance Workers	3,607	4,082	47,372	11.61	17
18	Housekeepers	17,356	18,218	167,369	9.19	18
19	Laundry					19
20	Administrator	1,845	2,086	78,125	37.45	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,707	11,600	146,182	12.60	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	1,164	1,236	12,783	10.34	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	3,734	3,734	12,985	3.48	33
34	TOTAL (lines 1 - 33)	149,798	161,852	\$ 2,054,307 *	\$ 12.69	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	117	\$ 5,243	01-03	35
36	Medical Director	Monthly	7,300	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	2,440	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	17	812	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>Director of Food Services</u>	Monthly	14,796	01-03	47
48	<u>Specialized Rehab Consultant</u>	Monthly	12,876	10A-03	48
49	TOTAL (lines 35 - 48)	134	\$ 76,407		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	8	323	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	8	\$ 323		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care

0031971

Report Period Beginning: 01/01/07

Ending: 12/31/07

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>78,125</u>	<u>Workers' Compensation Insurance</u>	\$ <u>32,843</u>	<u>IDPH License Fee</u>	\$ _____	
				<u>Unemployment Compensation Insurance</u>	<u>33,854</u>	<u>Advertising: Employee Recruitment</u>	<u>1,795</u>	
				<u>FICA Taxes</u>	<u>152,272</u>	<u>Health Care Worker Background Check</u>	<u>980</u>	
				<u>Employee Health Insurance</u>	<u>117,608</u>	(Indicate # of checks performed <u>82</u>)		
				<u>Employee Meals</u>	<u>15,841</u>	<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Advertising & Promotion</u>	<u>3,508</u>	
				<u>401k Matching Contributions</u>	<u>7,270</u>	<u>Dues & Subscriptions</u>	<u>15,868</u>	
				<u>Other Employee Benefits</u>	<u>3,231</u>	<u>Licenses and Permits</u>	<u>10,919</u>	
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
(List each licensed administrator separately.)								
\$ <u>78,125</u>				\$ <u>362,919</u>			\$ <u>31,365</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>21,176</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>In-State Travel</u>	
<u>See Supplemental Schedule</u>			<u>329,018</u>					
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL			Seminar Expense	
(Attach a copy of any management service agreement)							<u>1,085</u>	
\$ <u>398,386</u>				\$ _____			<u>Alloc. - Preferred Bookkeeping</u>	
							<u>20</u>	
C. Professional Services							<u>Alloc. - S.I.R. Management</u>	
Vendor/Payee	Type	Amount					<u>212</u>	
<u>FR&R</u>	<u>Accounting</u>	\$ <u>12,875</u>					<u>Entertainment Expense</u>	
<u>Preferred Bookkeeping</u>	<u>Accounting</u>	<u>37,125</u>					(_____)	
<u>Legal Fees</u>	<u>See Attached</u>	<u>5,674</u>					TOTAL (agree to Sch. V, line 24, col. 8)	
<u>SIR Management</u>	<u>Dir of Regulatory Services</u>	<u>11,748</u>					\$ <u>1,317</u>	
<u>SIR Management</u>	<u>Computer</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>1,861</u>						
<u>HDSI</u>	<u>Data Systems</u>	<u>1,582</u>						
<u>Property Valuation</u>	<u>Real Estate</u>	<u>2,500</u>						
<u>Prior Year Legal - Adj on 5A</u>	<u>Legal</u>	<u>19,625</u>						
<u>LTC Solutions</u>	<u>MDS Software</u>	<u>1,500</u>						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL				
(If total legal fees exceed \$5,000, attach copy of invoices.)				\$ <u>148,430</u>				

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number Greenwood Care

Report Period Beginning: 01/01/07 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 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. 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? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,799 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 79,388
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 15,841 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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT