



Facility Name & ID Number Greenwood Care

# 0031971 Report Period Beginning: 01/01/09 Ending: 12/31/09

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 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	48,148	551		48,699	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,148	551		48,699	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.02%

D. How many bed-hold days during this year were paid by the Department? 1,653 (Do not include bed-hold days in Section B.)

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

N/A

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

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

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

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

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/09 Ending: 12/31/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	179,019	20,123	24,648	223,790		223,790	(10,983)	212,807		1
2	Food Purchase		216,300		216,300	(17,246)	199,054	(24)	199,029		2
3	Housekeeping	186,724	37,599		224,323		224,323	(1,194)	223,129		3
4	Laundry		12,603	11,815	24,418		24,418	(268)	24,150		4
5	Heat and Other Utilities			123,904	123,904		123,904	1,685	125,589		5
6	Maintenance	57,392	43,205	130,957	231,554		231,554	(13,004)	218,550		6
7	Other (specify):*							3,880	3,880		7
8	<b>TOTAL General Services</b>	423,135	329,830	291,324	1,044,289	(17,246)	1,027,043	(19,909)	1,007,134		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,300	6,300		6,300		6,300		9
10	Nursing and Medical Records	1,112,795	37,992	72,435	1,223,222		1,223,222	(17,762)	1,205,460		10
10a	Therapy			15,660	15,660		15,660	(11,690)	3,970		10a
11	Activities	163,838	17,240	2,698	183,776		183,776		183,776		11
12	Social Services	279,263			279,263		279,263		279,263		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							3,068	3,068		15
16	<b>TOTAL Health Care and Programs</b>	1,555,896	55,232	97,093	1,708,221		1,708,221	(26,384)	1,681,837		16
	<b>C. General Administration</b>										
17	Administrative	79,815		446,905	526,720		526,720	(358,566)	168,154		17
18	Directors Fees										18
19	Professional Services			135,399	135,399		135,399	(101,698)	33,701		19
20	Dues, Fees, Subscriptions & Promotions			47,051	47,051		47,051	(24,947)	22,104		20
21	Clerical & General Office Expenses	112,751	26,369	85,319	224,439		224,439	37,131	261,570		21
22	Employee Benefits & Payroll Taxes			371,903	371,903	17,246	389,149		389,149		22
23	Inservice Training & Education										23
24	Travel and Seminar			998	998		998	284	1,282		24
25	Other Admin. Staff Transportation			4,882	4,882		4,882	6,821	11,703		25
26	Insurance-Prop.Liab.Malpractice			107,996	107,996		107,996	907	108,903		26
27	Other (specify):*							30,123	30,123		27
28	<b>TOTAL General Administration</b>	192,566	26,369	1,200,453	1,419,388	17,246	1,436,634	(409,945)	1,026,689		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,171,597	411,431	1,588,870	4,171,898		4,171,898	(456,238)	3,715,660		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 &amp; ID Number

Greenwood Care

#0031971

Report Period Beginning:

01/01/09

Ending:

12/31/09

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			57,010	57,010		57,010	218,140	275,150			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			38,569	38,569		38,569	468,354	506,923			32
33	Real Estate Taxes							128,831	128,831			33
34	Rent-Facility & Grounds			876,600	876,600		876,600	(876,600)				34
35	Rent-Equipment & Vehicles			6,671	6,671		6,671	6,743	13,414			35
36	Other (specify):*							20,464	20,464			36
37	<b>TOTAL Ownership</b>			978,850	978,850		978,850	(34,068)	944,782			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			79,388	79,388		79,388		79,388			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			79,388	79,388		79,388		79,388			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,171,597	411,431	2,647,108	5,230,136		5,230,136	(490,306)	4,739,830			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:

01/01/09

Ending:

12/31/09

**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	118,760	30		9
10	Interest and Other Investment Income	(30,358)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(24)	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	(3,441)	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	(20,151)	21		24
25	Fund Raising, Advertising and Promotional	(9,038)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,200)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(69,619)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (17,071)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(473,234)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (473,234)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (490,306)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Greenwood Care

ID# 0031971

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Misc. Income	\$ (17)	21	1
2	Bank Fees	(5,965)	21	2
3	Theft & Damage	(2,455)	21	3
4	COPE Dues	(4,161)	20	4
5	Capitalized R&M	(11,733)	06	5
6	Alliance for Living - PAC Dues	(8,517)	20	6
7	Additional R&M	8,125	06	7
8	Building Company - Fees	(10,044)	21	8
9	Building Company - Professional Fees	(7,350)	19	9
10	Building Company - Office Expense	(1,411)	21	10
11	Building Company - Amortization	(24,935)	36	11
12	Building Company - Replacement Tax	(1,156)	21	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
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	<b>Total</b>	(69,619)		49

Greenwood Care

ID# 0031971

Report Period Beginning: 01/01/09

Ending: 12/31/09

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

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Greenwood Care# 0031971

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				(10,983)								(10,983)	1
2	Food Purchase	(24)											(24)	2
3	Housekeeping					(1,194)							(1,194)	3
4	Laundry					(268)							(268)	4
5	Heat and Other Utilities				1,685								1,685	5
6	Maintenance	(3,608)	3,631	(7,345)	(5,682)								(13,004)	6
7	Other (specify):*			668	3,212								3,880	7
8	<b>TOTAL General Services</b>	<b>(3,632)</b>	<b>3,631</b>	<b>(6,677)</b>	<b>(11,768)</b>	<b>(1,462)</b>							<b>(19,909)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records			(20,504)	5,357	(2,615)							(17,762)	10
10a	Therapy				(11,690)								(11,690)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			1,631	1,437								3,068	15
16	<b>TOTAL Health Care and Programs</b>			<b>(18,873)</b>	<b>(4,896)</b>	<b>(2,615)</b>							<b>(26,384)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(420,502)	61,936								(358,566)	17
18	Directors Fees													18
19	Professional Services	(7,350)	7,350	(112,542)	10,844								(101,698)	19
20	Fees, Subscriptions & Promotions	(25,157)		210									(24,947)	20
21	Clerical & General Office Expenses	(44,399)	12,611	68,870	49								37,131	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			284									284	24
25	Other Admin. Staff Transportation			6,821									6,821	25
26	Insurance-Prop.Liab.Malpractice			807	100								907	26
27	Other (specify):*			17,633	12,490								30,123	27
28	<b>TOTAL General Administration</b>	<b>(76,906)</b>	<b>19,961</b>	<b>(438,419)</b>	<b>85,419</b>								<b>(409,945)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(80,538)</b>	<b>23,592</b>	<b>(463,969)</b>	<b>68,755</b>	<b>(4,077)</b>							<b>(456,238)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Greenwood Care# 0031971

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	118,760	91,308		8,072								218,140	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(30,358)	511,418	(17,985)	5,279								468,354	32
33	Real Estate Taxes		123,780		5,051								128,831	33
34	Rent-Facility & Grounds		(876,600)										(876,600)	34
35	Rent-Equipment & Vehicles			6,743									6,743	35
36	Other (specify):*	(24,935)	45,399										20,464	36
37	<b>TOTAL Ownership</b>	<b>63,467</b>	<b>(104,695)</b>	<b>(11,242)</b>	<b>18,402</b>								<b>(34,068)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>													<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(17,071)	(81,103)	(475,211)	87,157	(4,077)							(490,306)	45

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 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	\$ 876,600	Greenwood Care, LLC	100.00%	\$	\$ (876,600)	1
2	V	32 Interest Income	102,349	Greenwood Care, LLC	100.00%		(102,349)	2
3	V	36 Amortization of Loan Fees		Greenwood Care, LLC	100.00%	24,935	24,935	3
4	V	06 Building R&M		Greenwood Care, LLC	100.00%	3,631	3,631	4
5	V	33 Real Estate Taxes		Greenwood Care, LLC	100.00%	123,780	123,780	5
6	V	30 Depreciation		Greenwood Care, LLC	100.00%	91,308	91,308	6
7	V	21 Replacement Tax		Greenwood Care, LLC	100.00%	1,156	1,156	7
8	V	21 Fees		Greenwood Care, LLC	100.00%	9,694	9,694	8
9	V	21 Filing Fees		Greenwood Care, LLC	100.00%	350	350	9
10	V	32 Mortgage Interest		Greenwood Care, LLC	100.00%	613,767	613,767	10
11	V	36 Mortgage Insurance		Greenwood Care, LLC	100.00%	20,464	20,464	11
12	V	21 Office Expense		Greenwood Care, LLC	100.00%	1,411	1,411	12
13	V	19 Professional Fees		Greenwood Care, LLC	100.00%	7,350	7,350	13
14	Total		\$ 978,949			\$ 897,846	\$ * (81,103)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 REPAIRS AND MAINT.	\$ 15,660	S.I.R. MANAGEMENT, INC.	100.00%	\$ 8,315	\$ (7,345)
16	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	668	668
17	V	10 NURSING	31,320	S.I.R. MANAGEMENT, INC.	100.00%	10,816	(20,504)
18	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	1,631	1,631
19	V	19 PROFESSIONAL FEES	114,948	S.I.R. MANAGEMENT, INC.	100.00%	1,810	(113,138)
20	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	210	210
21	V	21 CLERICAL & GENERAL	31,320	S.I.R. MANAGEMENT, INC.	100.00%	24,780	(6,540)
22	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	284	284
23	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	6,821	6,821
24	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	807	807
25	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	3,173	3,173
26	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(17,985)	(17,985)
27	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	6,743	6,743
28	V						
29	V	17 ADMINISTRATIVE	439,069	S.I.R. MANAGEMENT, INC.	100.00%	18,567	(420,502)
30	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	596	596
31	V	21 CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	75,410	75,410
32	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	14,460	14,460
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 632,317			\$ 157,106	\$ * (475,211)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1	DIETARY SALARIES	\$ 15,660	S.I.R. MANAGEMENT, INC.	100.00%	\$ 4,677	\$ (10,983)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	723	723	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	5,357	5,357	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	814	814	18
19	V	17	ADMIN./LEGAL SALARIES	7,836	S.I.R. MANAGEMENT, INC.	100.00%	69,772	61,936	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	10,803	10,803	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	12,490	12,490	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	15,660	S.I.R. MANAGEMENT, INC.	100.00%	3,970	(11,690)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	623	623	25
26	V								26
27	V	6	MAINTENANCE SALARIES	19,826	S.I.R. MANAGEMENT, INC.	100.00%	13,662	(6,164)	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	2,489	2,489	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	1,685	1,685	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	482	482	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	41	41	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	49	49	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	100	100	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	8,072	8,072	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	5,279	5,279	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	5,051	5,051	37
38	V								38
39	Total		\$ 58,982				\$ 146,139	\$ * 87,157	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	13,002	Xcel Supply, LLC	100.00%	11,808	(1,194)	16
17	V	4 Laundry	2,921	Xcel Supply, LLC	100.00%	2,653	(268)	17
18	V	6 Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10 Nursing	28,479	Xcel Supply, LLC	100.00%	25,864	(2,615)	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	<b>Total</b>		\$ 44,402			\$ 40,324	\$ * (4,077)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 120,849	\$ 120,849	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	120,849	CCS Employee Benefits Group	100.00%		(120,849)	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		\$ 120,849			\$ 120,849	\$ *	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: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

**VII. RELATED PARTIES (continued)**

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

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

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

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

Facility Name &amp; ID Number

Greenwood Care

# 0031971

Report Period Beginning:

01/01/09

Ending:

12/31/09

## 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	4.83%	See Attached	1.81	4.53%	Alloc. Sallary	\$ 11,779	17-7	1
2	Michael Giannini	Owner	Administrative	3.45%	See Attached	2.11	5.28%	Alloc. Sallary	10,084	17-7	2
3	Eric Rothner	Owner	Administrative	51.72%	See Attached	0.42	0.90%	Alloc. Sallary	6,041	17-7	3
4	Nenita Guzman	Relative	Dietary	N/A	See Attached	3.02	6.04%	Alloc. Sallary	4,677	1-7	4
5	Louise Bergthold	Owner	Administrative	3.45%	See Attached	3.32	6.04%	Alloc. Sallary	11,779	17-7	5
6	Tom Winter	Owner	Administrative	4.14%	See Attached	3.47	5.78%	Alloc. Sallary	11,283	17-7	6
7	Adam Vales	Relative	Clerical	N/A	See Attached	0.70	1.75%	Alloc. Sallary	1,268	22-7	7
8	Sarah Barrish	Relative	Administrative	N/A	See Attached	2.42	6.05%	Alloc. Sallary	6,160	17-7	8
9	Kirsten Barrish	Relative	Clerical	N/A	See Attached	1.03	6.06%	Alloc. Sallary	816	21-7	9
10											10
11											11
12											12
13								TOTAL	\$ 63,887		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:

01/01/09

Ending: 12/31/09

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	6	REPAIRS AND MAINT.	PATIENT DAYS	806,183	12	\$ 137,654	\$ 73,265	48,699	\$ 8,315	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	806,183	12	11,057		48,699	668	2
3	10	NURSING	PATIENT DAYS	806,183	12	179,054	179,054	48,699	10,816	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	806,183	12	27,001		48,699	1,631	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	806,183	12	29,965	15,891	48,699	1,810	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	806,183	12	3,480		48,699	210	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	806,183	12	410,223	335,902	48,699	24,780	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	806,183	12	4,701		48,699	284	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	806,183	12	112,924		48,699	6,821	9
10	26	INSURANCE	PATIENT DAYS	806,183	12	13,360		48,699	807	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	806,183	12	52,522		48,699	3,173	11
12	32	INTEREST	PATIENT DAYS	806,183	12	(297,734)		48,699	(17,985)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	806,183	12	111,631		48,699	6,743	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	841,652	13	320,892	320,892	48,699	18,567	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	841,652	13	10,309		48,699	596	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	841,652	13	1,303,285	68,837	48,699	75,410	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	841,652	13	249,900		48,699	14,460	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,680,224	\$ 993,841		\$ 157,106	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/09

Ending: 12/31/09

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	806,183	12	\$ 77,418	\$ 77,418	48,699	\$ 4,677	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	806,183	12	11,962		48,699	723	2
3	10	NURSING SALARIES	PATIENT DAYS	806,183	12	88,682	88,682	48,699	5,357	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	806,183	12	13,479		48,699	814	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	806,183	12	1,155,033	1,155,033	48,699	69,772	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	806,183	12	178,836		48,699	10,803	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	806,183	12	206,767		48,699	12,490	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	273,348	13	69,299	69,299	15,660	3,970	10
11	15	EMPLOYEE BENEFITS	SPECIAL REHAB INC.	273,348	13	10,868		15,660	623	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	257,623	9	177,531	177,531	19,826	13,662	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	257,623	9	32,348		19,826	2,489	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	13	28,260		768	1,685	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	13	8,091		768	482	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	13	689		768	41	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	13	822		768	49	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	13	1,678		768	100	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	13	135,367		768	8,072	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	13	88,526		768	5,279	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	13	84,702		768	5,051	23
24										24
25	TOTALS					\$ 2,370,358	\$ 1,567,963		\$ 146,139	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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					11,808	2
3	4	Laundry	Direct Allocation					2,653	3
4	6	Repairs & Maintenance	Direct Allocation						4
5	10	Nursing	Direct Allocation					25,864	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				\$	\$		\$	40,324

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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		\$	\$		\$ 120,849	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				\$	\$		\$ 120,849	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/09

Ending: 12/31/09

**VIII. ALLOCATION OF INDIRECT COSTS**

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/09

Ending: 12/31/09

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/09

Ending: 12/31/09

**VIII. ALLOCATION OF INDIRECT COSTS**

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care

# 0031971 Report Period Beginning: 01/01/09 Ending: 12/31/09

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/09

Ending: 12/31/09

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Greenwood Care

# 0031971

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	The Private Bank		X	Mortgage				\$	12,278,100		\$	613,767	1						
2													2						
3													3						
4													4						
5	See Supplemental Schedule												5						
<b>Working Capital</b>																			
6	SIR Mgmt		X	Line of Credit					525,000			38,569	6						
7	S.I.R. Management Alloc.		X									(12,706)	7						
8	See Supplemental Schedule												8						
9	TOTAL Facility Related							\$	12,803,100		\$	639,629	9						
<b>B. Non-Facility Related*</b>																			
10	Interest Income		X									(30,358)	10						
11	Interest Income - Bldg. Co.		X									(102,349)	11						
12													12						
13	See Supplemental Schedule												13						
14	TOTAL Non-Facility Related							\$			\$	(132,707)	14						
15	TOTALS (line 9+line14)							\$	12,803,100		\$	506,923	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 20,464 Line # 36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Greenwood Care

# 0031971

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

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

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

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

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:

01/01/09

Ending:

12/31/09

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/09

Ending:

12/31/09

**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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Various		1984	2,672		20	76	76	1,802	9
10	Various		1987	24,869		20	694	694	17,040	10
11	Various		1988	27,733		20	321	321	18,715	11
12	Various		1989	7,668		20	183	183	5,332	12
13	Various		1990	9,800		20	490	490	8,896	13
14	Various		1992	25,025		20	1,244	1,244	22,493	14
15	Various		1993	63,911		20	3,195	3,195	53,530	15
16	Various		1994	20,319		20	1,017	1,017	15,636	16
17	Various		1995	73,839		20	3,693	3,693	53,876	17
18	Various		1996	109,220		20	5,461	5,461	74,004	18
19	Various		1997	73,171		20	3,658	3,658	45,754	19
20	Various		1998	58,371		20	2,919	2,919	33,501	20
21	Various		1999	179,834		20	9,099	9,099	95,638	21
22	Various		2000	171,876		20	8,594	8,594	83,434	22
23	Various		2001	43,730		20	2,186	2,186	19,344	23
24	Various		2002	87,606		20	5,331	5,331	39,940	24
25	Various		2003	59,109		20	4,205	4,205	26,285	25
26	Various		2004	77,107		20	4,571	4,571	25,778	26
27	Various		2005	58,861		20	3,279	3,279	14,511	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:

01/01/09

Ending:

12/31/09

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	Related Building Company (Pages 12F & 12G)	2,647,692	91,308		149,672	58,364	1,522,982	67
68	Related Party Allocations (Pages 12H & 12I)	95,759	3,923		3,086	(837)	39,517	68
69	Financial Statement Depreciation		57,010			(57,010)		69
70	TOTAL (lines 4 thru 69)	\$ 3,918,172	\$ 152,241		\$ 212,974	\$ 60,733	\$ 2,218,008	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/09

Ending:

12/31/09

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,918,172	\$ 152,241		\$ 212,974	\$ 60,733	\$ 2,218,008	1
2	Fire Doors	2006			20				2
3	Elevator Generator	2006	2,021		20	101	101	404	3
4	Boiler Valve	2006	4,996		20	250	250	916	4
5	Elevator Generator	2006	4,800		20	240	240	780	5
6	Boiler-Tank	2006	9,500		20	475	475	1,465	6
7	Tank-Boiler	2006	3,220		20	161	161	496	7
8	Hvac Condensor	2006	1,901		20	95	95	364	8
9	Sprinkler-Nova	2006	200,371		20	10,019	10,019	35,900	9
10	Sprinkler-Olympic	2006	12,000		20	600	600	2,150	10
11	Sprinkler-Sbs	2006	8,574		20	429	429	1,536	11
12	Sprinkler-Permit	2006	5,920		20	296	296	1,061	12
13	Plumbing Work	2006	4,800		20	240	240	920	13
14	Flooring	2006	2,680		20	134	134	480	14
15	Radiators	2006	2,104		20	105	105	333	15
16	Fire Doors	2006	2,450		20	123	123	378	16
17	Privacy Fire Door	2006	6,125		20	306	306	970	17
18	Fire Door	2007	2,925		20	293	293	853	18
19	Fire Door	2007	1,725		20	173	173	489	19
20	Sprinkler	2007	126,027		20	6,301	6,301	16,804	20
21	Boiler Work	2007	3,970		20	199	199	579	21
22	Fire Door	2007	1,175		20	118	118	304	22
23	Elevator Generator	2007	8,500		20	425	425	1,275	23
24	Fire Doors	2007	1,275		20	128	128	308	24
25	Elevator	2007	5,720		20	286	286	644	25
26	Bathroom Repairs	2007	2,560		20	128	128	299	26
27	Lighting	2008	4,653		20	233	233	427	27
28	Smoke Detectors	2008	3,732		20	187	187	342	28
29	Elevator Work	2008	8,954		20	448	448	485	29
30	Plumbing Repairs	2008	6,700		20	335	335	391	30
31	Elevator Repair	2008	5,000		20	250	250	417	31
32	Boiler Work	2009	4,839		20	242	242	242	32
33	Phone System	2009	10,392		20	476	476	476	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,387,781	\$ 152,241		\$ 236,770	\$ 84,529	\$ 2,290,496	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,387,781	\$ 152,241		\$ 236,770	\$ 84,529	\$ 2,290,496	1
2	2009	4,060		20	135	135	135	2
3	2009	5,711		20	71	71	71	3
4	2009	3,105		20	155	155	155	4
5	2009	4,889		20	244	244	244	5
6	2009	3,739		20	187	187	187	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		\$ 4,409,285	\$ 152,241		\$ 237,563	\$ 85,322	\$ 2,291,289	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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,409,285	\$ 152,241		\$ 237,563	\$ 85,322	\$ 2,291,289	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)	\$ 4,409,285	\$ 152,241		\$ 237,563	\$ 85,322	\$ 2,291,289	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,409,285	\$ 152,241		\$ 237,563	\$ 85,322	\$ 2,291,289	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)	\$ 4,409,285	\$ 152,241		\$ 237,563	\$ 85,322	\$ 2,291,289	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/09

Ending:

12/31/09

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Building Company Information</b>								1
2	<b>Buildings:</b>								2
3	<b>Greenwood Care, LTD</b>	1969	1,845,500	91,308		113,703	22,395	1,475,478	3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	<b>Rear Freight Elevator</b>	2008	141,600		20	7,080	7,080	14,160	9
10	<b>Matthews Roofing - Masonry Work</b>	2008	55,300		20	2,765	2,765	5,530	10
11	<b>Flooring</b>	2008	4,648		20	232	232	464	11
12	<b>Nurses Stations - Cabinetry and Sinks</b>	2008	29,158		20	1,458	1,458	2,916	12
13									13
14									14
15	<b>Generator - Application/Permits, Engineering Cost</b>	2009	16,844		30	561	561	561	15
16	<b>Generator Cost and Installation</b>	2009	189,600		30	6,320	6,320	6,320	16
17	<b>Bathrooms-Valves, New Walls, Tiles, New Toilet, Sink</b>	2009	42,000		20	2,100	2,100	2,100	17
18	<b>Shower Room - Wall Work, Concrete, New Rubber Pan, Tiles</b>	2009	4,375		20	219	219	219	18
19	<b>Bathrooms-Valves, New Walls, Tiles, New Toilet, Sink</b>	2009	52,500		20	2,625	2,625	2,625	19
20	<b>Bathrooms-Valves, New Walls, Tiles, New Toilet, Sink</b>	2009	94,500		20	4,725	4,725	4,725	20
21	<b>Generator</b>	2009	3,071		20	154	154	154	21
22	<b>Bathrooms-Valves, New Walls, Tiles, New Toilet, Sink</b>	2009	42,000		30	1,400	1,400	1,400	22
23	<b>Bathrooms-Valves, New Walls, Tiles, New Toilet, Sink</b>	2009	63,000		20	3,150	3,150	3,150	23
24	<b>Bathrooms-Valves, New Walls, Tiles, New Toilet, Sink</b>	2009	47,250		20	2,363	2,363	2,363	24
25	<b>Roofing Work</b>	2009	16,346		20	817	817	817	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$	\$		\$	\$	\$	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 (12F & 12G lines 1 thru 33)	\$ 2,647,692	\$ 91,308		\$ 149,672	\$ 58,364	\$ 1,522,982	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/09

Ending:

12/31/09

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Related Party Information</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3	<u>S.I.R. Properties - S.I.R. Management - Allocation</u>	1993	26,993	857	35	771	(86)	12,725	3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	<u>S.I.R. Management Inc.</u>	1993	6,844	191	20	339	148	5,768	9
10	<u>S.I.R. Management Inc.</u>	1994	21		20			21	10
11	<u>S.I.R. Management Inc.</u>	1995	156		20	8	8	113	11
12	<u>S.I.R. Management Inc.</u>	1997	10,516	235	20	526	291	6,735	12
13	<u>S.I.R. Management Inc.</u>	1999	827		20	41	41	424	13
14	<u>S.I.R. Management Inc.</u>	1999	8,112		20			8,112	14
15	<u>S.I.R. Management Inc.</u>	2000	976		20	49	49	466	15
16	<u>S.I.R. Management Inc.</u>	2007	3,137	559	20	157	(402)	344	16
17	<u>S.I.R. Management Inc.</u>	2008	8,644	864	20	545	(319)	1,005	17
18	<u>S.I.R. Management Inc.</u>	2009	21,480	43	20	263	220	263	18
19									19
20	<u>S.I.R. Properties - S.I.R. Management - Allocation</u>	2009	1,621	926	20	65	(861)	65	20
21	<u>S.I.R. Properties - S.I.R. Management - Allocation</u>	2007	473	68	20	24	(44)	71	21
22	<u>S.I.R. Properties - S.I.R. Management - Allocation</u>	2002	107		20	5	5	40	22
23	<u>S.I.R. Properties - S.I.R. Management - Allocation</u>	1999	3,420	171	20	171		1,796	23
24	<u>S.I.R. Properties - S.I.R. Management - Allocation</u>	1998	1,635		20	82	82	940	24
25	<u>S.I.R. Properties - S.I.R. Management - Allocation</u>	1997	102		20	5	5	69	25
26	<u>S.I.R. Properties - S.I.R. Management - Allocation</u>	1994	257	7	20	13	6	199	26
27	<u>S.I.R. Properties - S.I.R. Management - Allocation</u>	1993	438	2	20	22	20	361	27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12H & 12I lines 1 thru 33)	\$ 95,759	\$ 3,923		\$ 3,086	\$ (837)	\$ 39,517	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:

01/01/09

Ending:

12/31/09

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	\$ 477,969	\$ 4,021	\$ 32,571	\$ 28,550	10	\$ 320,937	71
72	Current Year Purchases	39,778	127	2,277	2,150	10	2,277	72
73	Fully Depreciated Assets	189,335		215	215	10	189,335	73
74								74
75	TOTALS	\$ 707,082	\$ 4,148	\$ 35,063	\$ 30,915		\$ 512,549	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	\$	\$ 2,523	\$ 2,523	5	\$ 8,249	76
77										77
78										78
79										79
80	TOTALS			\$ 14,137	\$	\$ 2,523	\$ 2,523		\$ 8,249	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)	\$ 5,283,059	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 156,389	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 275,149	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 118,760	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,812,087	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

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: \$ 13,414 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_/2009 \$ \_\_\_\_\_

13. \_\_\_\_\_/2010 \$ \_\_\_\_\_

14. \_\_\_\_\_/2011 \$ \_\_\_\_\_

\* 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		Contract	Total
		1	2		
		Drop-outs	Completed		
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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	N/A	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <a href="#">See Supplemental</a>									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: 01/01/09Ending: 12/31/09

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 12,760	\$ 35,519	1
2	Cash-Patient Deposits	23,380	23,380	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	647,281	647,281	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	32,540	134,857	6
7	Other Prepaid Expenses	2,850	2,850	7
8	Accounts Receivable (owners or related parties)	87,653	87,653	8
9	Other(specify): <u>See Attached Schedule</u>	244,870	1,151,885	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,051,334	\$ 2,083,425	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		152,555	13
14	Buildings, at Historical Cost		2,274,062	14
15	Leasehold Improvements, at Historical Cost	993,251	1,782,336	15
16	Equipment, at Historical Cost	955,848	1,301,576	16
17	Accumulated Depreciation (book methods)	(1,108,808)	(2,752,353)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>		165,173	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 840,291	\$ 2,923,349	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,891,625	\$ 5,006,774	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 127,783	\$ 178,135	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,125	24,125	28
29	Short-Term Notes Payable	525,000	525,000	29
30	Accrued Salaries Payable	198,521	198,521	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,618	4,618	31
32	Accrued Real Estate Taxes(Sch.IX-B)		123,000	32
33	Accrued Interest Payable		49,112	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,000	3,000	35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>	1,756	89,409	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 884,803	\$ 1,194,920	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,278,100	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 12,278,100	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 884,803	\$ 13,473,020	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,006,822	\$ (8,466,246)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,891,625	\$ 5,006,774	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,073,542</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Rounding</b>	<b>(3)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,073,539</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>212,408</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(279,125)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(66,717)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,006,822</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care# 0031971Report Period Beginning: 01/01/09Ending: 12/31/09

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,410,969	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,410,969	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	30,358	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 30,358	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	1,217	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,217	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,442,544	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,044,289	31
32	Health Care	1,708,221	32
33	General Administration	1,419,388	33
<b>B. Capital Expense</b>			
34	Ownership	978,850	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	79,388	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,230,136	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	212,408	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 212,408	43

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

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

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

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

Facility Name & ID Number Greenwood Care

# 0031971

Report Period Beginning:

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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	1,735	2,062	\$ 61,940	\$ 30.04	1
2	Assistant Director of Nursing	1,842	2,086	53,840	25.81	2
3	Registered Nurses	90	90	2,347	26.08	3
4	Licensed Practical Nurses	13,544	15,559	384,751	24.73	4
5	CNAs & Orderlies	47,496	51,171	592,962	11.59	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,859	2,080	31,353	15.07	9
10	Activity Assistants	13,340	14,204	132,485	9.33	10
11	Social Service Workers	15,464	16,572	279,263	16.85	11
12	Dietician	2,037	2,086	32,938	15.79	12
13	Food Service Supervisor					13
14	Head Cook	5,491	5,862	54,457	9.29	14
15	Cook Helpers/Assistants	9,713	10,174	91,624	9.01	15
16	Dishwashers					16
17	Maintenance Workers	3,629	4,006	57,392	14.33	17
18	Housekeepers	17,596	20,237	186,724	9.23	18
19	Laundry					19
20	Administrator	1,941	2,086	79,815	38.26	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,064	16,414	112,751	6.87	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	1,418	1,517	16,955	11.18	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	152,259	166,206	\$ 2,171,597 *	\$ 13.07	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	176	\$ 8,988	01-03	35
36	Medical Director	Monthly	6,300	09-03	36
37	Medical Records Consultant	Monthly	4,778	10-03	37
38	Nurse Consultant	Monthly	31,320	10-03	38
39	Pharmacist Consultant	Monthly	2,463	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,698	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>Specialized Rehab Consultant</u>	Monthly	15,660	10A-03	47
48	<u>Director of Food Services</u>	Monthly	15,660	01-03	48
49	TOTAL (lines 35 - 48)	176	\$ 87,867		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	935	33,874	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	935	\$ 33,874		53

SEE ACCOUNTANTS' COMPILATION REPORT



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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Greenwood Care

# 0031971

Report Period Beginning:

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**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 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,939 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. \$ 17,246 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.