FOR BHF USE

LL1

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

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0031971

Facility Name: Greenwood Care

Address: 1406 Chicago Avenue (Number) Evanston (City) 60201 (Zip Code)

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 1/1/1990

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda **Telephone Number:** (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) * (Date)
** Subject to the attached Accountants Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	145	Intermediate (ICF)	145	53,070	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	145	TOTALS	145	53,070	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	21,489	1,509	24,359	47,357	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,489	1,509	24,359	47,357	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.23%

D. How many bed-hold days during this year were paid by the Department?
None (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 [X]

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

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 [X] Date 2/1/1987 NO [ ]

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

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							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	201,067	21,120	26,796	248,983		248,983	(10,890)	238,093			1
2	Food Purchase		244,037		244,037	(20,112)	223,925	(1,177)	222,748			2
3	Housekeeping	217,769	35,950		253,719		253,719	(2,220)	251,499			3
4	Laundry		15,266	23,778	39,044		39,044	(386)	38,658			4
5	Heat and Other Utilities			111,094	111,094		111,094	(13,148)	97,946			5
6	Maintenance	52,948	33,844	165,051	251,843		251,843	(17,786)	234,057			6
7	Other (specify):*							7,671	7,671			7
8	**TOTAL General Services**	471,784	350,217	326,719	1,148,720	(20,112)	1,128,608	(37,936)	1,090,672			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800	997	5,797			9
10	Nursing and Medical Records	1,071,613	27,447	55,756	1,154,816		1,154,816	(5,793)	1,149,023			10
10a	Therapy	36,851		24,360	61,211		61,211	(11,786)	49,425			10a
11	Activities	150,595	14,457	680	165,732		165,732		165,732			11
12	Social Services	230,113		3,600	233,713		233,713		233,713			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							7,811	7,811			15
16	**TOTAL Health Care and Programs**	1,489,172	41,904	89,196	1,620,272		1,620,272	(8,771)	1,611,501			16
	C. General Administration											
17	Administrative	88,195		342,071	430,266		430,266	(237,161)	193,105			17
18	Directors Fees											18
19	Professional Services			229,632	229,632	(3,397)	226,235	(148,068)	78,167			19
20	Dues, Fees, Subscriptions & Promotions			51,473	51,473		51,473	(20,340)	31,133			20
21	Clerical & General Office Expenses	185,028	18,488	48,820	252,336		252,336	87,041	339,377			21
22	Employee Benefits & Payroll Taxes			379,331	379,331	20,112	399,443		399,443			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,177	4,177		4,177	468	4,645			24
25	Other Admin. Staff Transportation			3,168	3,168		3,168	6,886	10,054			25
26	Insurance-Prop.Liab.Malpractice			111,572	111,572		111,572	10,727	122,299			26
27	Other (specify):*							31,762	31,762			27
28	**TOTAL General Administration**	273,223	18,488	1,170,244	1,461,955	16,715	1,478,670	(268,685)	1,209,985			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,234,179	410,609	1,586,159	4,230,947	(3,397)	4,227,550	(315,392)	3,912,157			29

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

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

Facility Name & ID Number Greenwood Care #0031971 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			41,377	41,377		41,377	145,115	186,492			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,481	10,481		10,481	370,942	381,423			32
33	Real Estate Taxes					3,397	3,397	204,348	207,745			33
34	Rent-Facility & Grounds			996,000	996,000		996,000	(996,000)				34
35	Rent-Equipment & Vehicles			6,048	6,048		6,048	5,087	11,135			35
36	Other (specify):*							61,102	61,102			36
37	**TOTAL Ownership**			1,053,906	1,053,906	3,397	1,057,303	(209,406)	847,897			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)**	2,234,179	410,609	2,640,065	5,284,853	0	5,284,853	(524,798)	4,760,055			45

THE TOTAL FOR COLUMN 5 MUST BE ZERO,PLEASE CORRECT

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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(15,033)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(27,627)	30		9
10	Interest and Other Investment Income	(19,602)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(77)	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	(8,137)	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	(12,481)	21		24
25	Fund Raising, Advertising and Promotional	(4,714)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(65,871)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (154,542)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(370,256)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (370,256)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (524,798)		37

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

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

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

Greenwood Care

ID# 0031971

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Allowable Legal	$ (254)	19	1
2	Bank Fees	(7,434)	21	2
3	Theft and Damage Loss	(312)	21	3
4	Vending Income	(1,100)	02	4
5	Additional R&M	1,949	06	5
6	Capitalized R&M	(17,106)	06	6
7	Prior Period Pharmacy Expense	(1,500)	10	7
8	PAC Dues	(9,120)	20	8
9	Building Co - Filing Fees	(350)	21	9
10	Building Co - Office Expense	(12)	21	10
11	Building Co - Professional Fees	(30,633)	19	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
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(65,871)		49

Greenwood Care

ID# 0031971

Report Period Beginning: 01/01/16

Ending: 12/31/16

	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	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Greenwood Care # 0031971 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary				(10,890)								(10,890)	1
2	Food Purchase	(1,177)											(1,177)	2
3	Housekeeping					(2,220)							(2,220)	3
4	Laundry					(386)							(386)	4
5	Heat and Other Utilities	(15,033)			1,885								(13,148)	5
6	Maintenance	(15,157)	3,108	(15,630)	9,923	(30)							(17,786)	6
7	Other (specify):*				7,671								7,671	7
8	**TOTAL General Services**	(31,367)	3,108	(15,630)	8,589	(2,636)							(37,936)	8
	B. Health Care and Programs													
9	Medical Director			997									997	9
10	Nursing and Medical Records	(1,500)		(8,896)	7,053	(1,490)	(961)						(5,793)	10
10a	Therapy				(11,786)								(11,786)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			4,359	3,452								7,811	15
16	**TOTAL Health Care and Programs**	(1,500)		(3,540)	(1,281)	(1,490)	(961)						(8,771)	16
	C. General Administration													
17	Administrative			(319,470)	82,309								(237,161)	17
18	Directors Fees													18
19	Professional Services	(30,887)	30,633	(161,581)	13,767								(148,068)	19
20	Fees, Subscriptions & Promotions	(21,971)		1,631									(20,340)	20
21	Clerical & General Office Expenses	(21,589)	362	108,152	120		(5)						87,041	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			468									468	24
25	Other Admin. Staff Transportation			6,886									6,886	25
26	Insurance-Prop.Liab.Malpractice		8,888	1,672	167								10,727	26
27	Other (specify):*			11,610	20,152								31,762	27
28	**TOTAL General Administration**	(74,446)	39,883	(350,632)	116,515		(5)						(268,685)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(107,313)	42,991	(369,802)	123,823	(4,126)	(965)						(315,392)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Greenwood Care **#** 0031971 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(27,627)	166,812		5,930								145,115	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(19,602)	388,720	(3,879)	5,703								370,942	32
33	Real Estate Taxes		197,273		7,075								204,348	33
34	Rent-Facility & Grounds		(996,000)										(996,000)	34
35	Rent-Equipment & Vehicles			5,087									5,087	35
36	Other (specify):*		61,102										61,102	36
37	**TOTAL Ownership**	(47,229)	(182,093)	1,208	18,708								(209,406)	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)**	(154,542)	(139,102)	(368,594)	142,531	(4,126)	(965)						(524,798)	45

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 996,000	Greenwood Care LLC	100.00%	$	$ (996,000)	1
2	V	21	Filing Fees		Greenwood Care LLC	100.00%	350	350	2
3	V	32	Interest	138	Greenwood Care LLC	100.00%	388,858	388,720	3
4	V	36	Mortgage Insurance		Greenwood Care LLC	100.00%	61,102	61,102	4
5	V	21	Office Expense		Greenwood Care LLC	100.00%	12	12	5
6	V	19	Professional Fees		Greenwood Care LLC	100.00%	30,633	30,633	6
7	V	26	Property Insurance		Greenwood Care LLC	100.00%	8,888	8,888	7
8	V	33	Real Estate Taxes	8,227	Greenwood Care LLC	100.00%	205,500	197,273	8
9	V	06	Repairs and Maintenance		Greenwood Care LLC	100.00%	3,108	3,108	9
10	V	30	Depreciation		Greenwood Care LLC	100.00%	166,812	166,812	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,004,365			$ 865,263	$ * (139,102)	14

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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS AND MAINT.	$ 20,880	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	$ 5,250	$ (15,630)	15
16	V	9	MEDICAL DIRECTOR CONSULTS		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	997	997	16
17	V	10	NURSING	41,760	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	32,864	(8,896)	17
18	V	15	EMP. BEN.-H.C.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	4,359	4,359	18
19	V	17	ADMINISTRATIVE		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	22,601	22,601	19
20	V	19	PROFESSIONAL FEES	165,540	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	3,959	(161,581)	20
21	V	20	FEES,SUBSCRIPTIONS		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	1,631	1,631	21
22	V	21	CLERICAL & GENERAL	6,960	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	115,112	108,152	22
23	V	24	EDUCATION & SEMINAR		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	468	468	23
24	V	25	OTHER ADMIN. STAFF TRANS.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	6,886	6,886	24
25	V	26	INSURANCE		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	1,672	1,672	25
26	V	27	EMP. BEN.-GEN. ADMIN.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	11,610	11,610	26
27	V	32	INTEREST		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	(3,879)	(3,879)	27
28	V	35	AUTO RENTAL		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	4,300	4,300	28
29	V	35	EQUIPMENT RENTAL		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	787	787	29
30	V								30
31	V	17	ADMINISTRATIVE	342,071	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%		(342,071)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 577,211			$ 208,617	$ * (368,594)	39

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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 17,400	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	$ 6,510	$ (10,890)	15
16	V	7	EMP. BEN.-DIETARY		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	1,140	1,140	16
17	V	10	NURSING SALARIES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	7,053	7,053	17
18	V	15	EMP. BEN.-NURSING		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	1,229	1,229	18
19	V	17	ADMIN./LEGAL SALARIES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	82,309	82,309	19
20	V	19	FIN. CONSULT./REGL. DIR.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	13,299	13,299	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	20,152	20,152	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	24,360	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	12,574	(11,786)	24
25	V	15	EMPLOYEE BENFITS		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	2,223	2,223	25
26	V								26
27	V	6	MAINTENANCE SALARIES	27,581	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	36,764	9,183	27
28	V	7	EMPLOYEE BENEFITS		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	6,531	6,531	28
29	V								29
30	V	5	UTILITIES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	1,885	1,885	30
31	V	6	REPAIRS AND MAINT.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	740	740	31
32	V	19	PROFESSIONAL FEES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	468	468	32
33	V	21	CLERICAL & GENERAL		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	120	120	33
34	V	26	INSURANCE		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	167	167	34
35	V	30	DEPRECIATION		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	5,930	5,930	35
36	V	32	INTEREST		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	5,703	5,703	36
37	V	33	REAL ESTATE TAXES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	7,075	7,075	37
38	V								38
39	Total			$ 69,341			$ 211,872	$ * 142,531	39

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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	Housekeeping	30,302	Big Ten Supply, LLC	100.00%	28,082	$ (2,220)	15
16	V	4	Laundry	5,264	Big Ten Supply, LLC	100.00%	4,879	(386)	16
17	V	6	Repairs & Maintenance	415	Big Ten Supply, LLC	100.00%	384	(30)	17
18	V	10	Nursing And Medical Records	20,331	Big Ten Supply, LLC	100.00%	18,841	(1,490)	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			$ 56,312			$ 52,186	$ * (4,126)	39

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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	$ 13,339	MAC Rx, LLC	100.00%	$ 12,379	$ (961)	15
16	V	21	Clerical & General Office Expenses	65	MAC Rx, LLC	100.00%	60	(5)	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			$ 13,404			$ 12,439	$ * (965)	39

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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ERIC ROTHNER	51.72%	GENERATIONS AT APPLEWOOD, LLC	MATTESON	GREENWOOD CARE LLC	LINCOLNWOOD	BUILDING CO.	1
2	DENNIS TOSSI	2.76%	BRYN MAWR CARE INC	CHICAGO	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	2
3	LOUISE BERGTHOLD	3.45%	GENERATIONS AT COLUMBUS PARK, INC	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	THOMAS WINTER	4.14%	DECATUR MANOR HEALTHCARE LLC	DECATUR	LONG TERM CARE LAB, LLC	LINCOLNWOOD	ANCILLARY SUPPLIES	4
5	MICHAEL R. GIANNINI TRUST DTD 3/13/00	3.45%	GENERATIONS AT ELMWOOD PARK, INC	ELMWOOD PARK	OAKTON ARMS	DES PLAINES	ASSISTED LIVING	5
6	CELESTE GIANNINI TRUST DTD 3/13/00	3.45%	ALBANY CARE INC	EVANSTON	MAC Rx LLC	DES PLAINES	PHARMACY	6
7	JULIANA R BARRISH TRUST DTD 1/26/93	15.52%	GENERATIONS AT NEIGHBORS, LLC	BYRON	GENERATIONS HEALTH NETW	LINCOLNWOOD	CONSULTING CO.	7
8	BRYAN BARRISH TRUST DTD 9/01/04	15.52%	GENERATIONS AT REGENCY, LLC	NILES	BIG TEN SUPPLY, LLC	LIBERTYVILLE	SUPPLY CO.	8
9			GENERATIONS AT ROCK ISLAND, LLC	ROCK ISLAND				9
10			WILSON CARE INC	CHICAGO				10
11			WESLEY REHABILITATION CENTER	AUBURN, IN				11
12			GENERATIONS AT OAKTON, LLC	DES PLAINES				12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

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

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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bryan Barrish	Relative	Administrative		See Attached	2.66	5.91%	Alloc. Salary	$ 13,299	17-7	1
2	Kirsten Schloss	Relative	Maintenance		See Attached	3.32	6.64%	Alloc. Salary	6,351	6-7	2
3	Sarah Barrish	Relative	Administrative		See Attached	3.32	6.64%	Alloc. Salary	8,200	17-7	3
4	Louise Bergthold	Owner	Administrative	3.45%	See Attached	3.99	6.65%	Alloc. Salary	13,299	17-7	4
5	Michael Giannini	Relative	Administrative		See Attached	2.33	5.83%	Alloc. Salary	11,304	17-7	5
6	Nenita Guzman	Relative	Dietary		See Attached	3.32	6.64%	Alloc. Salary	6,510	1-7	6
7	Tom Winter	Owner	Administrative	4.14%	See Attached	3.99	6.65%	Alloc. Salary	13,299	17-7	7
8	Thomas Bergthold	Relative	Clerical		See Attached	2.66	6.65%	Alloc. Salary	2,775	21-7	8
9	Clark Collins	Relative	Administrative		See Attached	0.92	2.30%	Alloc. Salary	1,147	Var	9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 76,184		13

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

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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 [X]

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

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

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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 [X] NO [ ]

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

Name of Related Organization: SIR MGMT.INC & GENERATIONS HC NETW
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	REPAIRS AND MAINT.	PATIENT DAYS	712,171	14	$ 78,945	$	47,357	$ 5,250	1
2	9	MEDICAL DIRECTOR CONSUL	PATIENT DAYS	712,171	14	15,000		47,357	997	2
3	10	NURSING	PATIENT DAYS	712,171	14	494,227		47,357	32,864	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	712,171	14	65,558	494,227	47,357	4,359	4
5	17	ADMINISTRATIVE	PATIENT DAYS	712,171	14	339,874	339,874	47,357	22,600	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	712,171	14	59,533		47,357	3,959	6
7	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	712,171	14	24,522		47,357	1,631	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	712,171	14	1,731,089	1,318,665	47,357	115,112	8
9	24	EDUCATION & SEMINAR	PATIENT DAYS	712,171	14	7,033		47,357	468	9
10	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	712,171	14	103,561		47,357	6,886	10
11	26	INSURANCE	PATIENT DAYS	712,171	14	25,150		47,357	1,672	11
12	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	712,171	14	174,591		47,357	11,610	12
13	32	INTEREST	PATIENT DAYS	712,171	14	(58,326)		47,357	(3,878)	13
14	35	AUTO RENTAL	PATIENT DAYS	712,171	14	64,663		47,357	4,300	14
15	35	EQUIPMENT RENTAL	PATIENT DAYS	712,171	14	11,842		47,357	787	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,137,262	$ 2,152,767		$ 208,617	25

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 [X] NO [ ]

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

Name of Related Organization: SIR MGMT.INC & GENERATIONS HC NETW
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	712,171	14	$ 97,898	$ 97,898	47,357	$ 6,510	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	712,171	14	17,139		47,357	1,140	2
3	10	NURSING SALARIES	PATIENT DAYS	712,171	14	106,059	106,059	47,357	7,053	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	712,171	14	18,488		47,357	1,229	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	712,171	14	1,237,797	1,115,138	47,357	82,309	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	712,171	14	200,000		47,357	13,299	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	712,171	14	303,056		47,357	20,152	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	322,920	13	166,688	166,688	24,360	12,574	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	322,920	13	29,469		24,360	2,223	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	335,151	14	446,742	446,742	27,581	36,764	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	335,151	14	79,358		27,581	6,531	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,878	14	28,358		856	1,885	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,878	14	11,129		856	740	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,878	14	7,038		856	468	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,878	14	1,812		856	120	19
20	26	INSURANCE	ALLOCATED SQ FT	12,878	14	2,507		856	167	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,878	14	89,214		856	5,930	21
22	32	INTEREST	ALLOCATED SQ FT	12,878	14	85,804		856	5,703	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,878	14	106,445		856	7,075	23
24										24
25	TOTALS					$ 3,035,001	$ 1,932,526		$ 211,872	25

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 [X] NO [ ]

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

Name of Related Organization: Big Ten Supply, LLC
Street Address: 15632 West Sprucewood Lane
City / State / Zip Code: Libertyville, IL 60048
Phone Number: (312)502-5882
Fax Number: (847)816-3425

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Direct Allocation						28,082	1
2	4	Laundry	Direct Allocation						4,879	2
3	6	Repairs & Maintenance	Direct Allocation						384	3
4	10	Nursing And Medical Records	Direct Allocation						18,841	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					$	$		$ 52,186	25

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 [X] NO [ ]

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

Name of Related Organization: MAC Rx, LLC
Street Address: 2307 S. Mount Prospect Road
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (224)220-2700
Fax Number: (224)220-2730

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing And Medical Records	Direct Allocation			$	$		$ 12,379	1
2	21	Clerical & General Office Expense	Direct Allocation						60	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					$	$		$ 12,439	25

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	The Private Bank		X	Mortgage			$	$ 11,005,231			$ 388,858	1
2												2
3												3
4												4
5					-							5
	Working Capital											
6	Lake Forest Bank		X	Line of Credit				120,000			10,481	6
7	Alloc from SIR Mgmt/Generations										5,703	7
8					-							8
9	TOTAL Facility Related						$	$ 11,125,231			$ 405,042	9
	B. Non-Facility Related*											
10	Interest Income		X								(19,602)	10
11	Interest Income -Bldg Co.		X								(138)	11
12	Alloc from SIR Mgmt/Generations										(3,879)	12
13					-							13
14	TOTAL Non-Facility Related						$	$			$ (23,619)	14
15	TOTALS (line 9+line14)						$	$ 11,125,231			$ 381,423	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 61,102 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.)

** 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: 01/01/16 Ending: 12/31/16

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

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

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:** 01/01/16 **Ending:** 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 204,000	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.)		$ 202,848	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,152)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 205,500	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.)		$ 3,397	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.		$ 207,745	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	179,522	8
	2012	188,087	9
	2013	193,972	10
	2014	193,911	11
	2015	195,773	12

2016 Accrual: $195,773 x 1.05 = $205,500 (Rounded)

Allocated from SIR Management Inc./Generations HC Network LLC = $7,075

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 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) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-18-324-019-0000	Long Term Care Property	$ 195,773.12	$ 195,773.12
2.	See Attached	Allocated from SIR	$ 123,678.12	$ 6,438.23
3.	See Attached	Allocated from Regency	$ 890,957.88	$ 719.55
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,210,409.12	$ 202,930.90

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

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

2015 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) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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 [X] 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	Facility		1987	$ 152,555	1
2					2
3	TOTALS			$ 152,555	3

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	145		1987	1969	$ 1,845,500	$	35	$	$	$ 1,845,500	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1984	2,672		20	76	76	2,336	9
10	Various			1987	24,869		20	694	694	21,898	10
11	Various			1988	27,733		20	321	321	20,961	11
12	Various			1989	7,668		20	87	87	5,940	12
13	Various			1990	9,800		20			9,235	13
14	Various			1992	25,025		20			25,019	14
15	Various			1993	63,911		20			63,906	15
16	Various			1994	20,319		20			20,315	16
17	Various			1995	73,839		20			73,839	17
18	Various			1996	109,220		20	2,447	2,447	109,217	18
19	Various			1997	73,171		20	3,657	3,657	71,362	19
20	Various			1998	58,371		20	2,919	2,919	53,931	20
21	Various			1999	179,834		20	9,098	9,098	159,322	21
22	Various			2000	171,876		20	8,594	8,594	143,590	22
23	Various			2001	43,730		20	2,187	2,187	34,650	23
24	Various			2002	87,606		20	3,432	3,432	68,174	24
25	Various			2003	59,109		20	1,707	1,707	47,523	25
26	Various			2004	77,107		20	3,142	3,142	53,975	26
27	Various			2005	58,861		20	2,613	2,613	36,534	27
28	Various			2006	271,462		20	13,573	13,573	143,165	28
29	Various			2007	153,877		20	8,049	8,049	77,895	29
30	Various			2008	29,039		20	1,452	1,452	12,225	30
31	Various			2009	36,735		20	1,837	1,837	13,942	31
32	Various			2010	11,568		20	1,157	1,157	7,037	32
33	Various			2011	11,264		20	826	826	4,837	33
34	Various			2012	56,176		20	3,138	3,138	14,570	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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		1,574,084	138,054		74,564	(63,490)	577,385	67
68	Related Party Allocations (Pages 12H & 12I)		145,804	3,543		5,128	1,585	79,702	68
69	Financial Statement Depreciation			41,377			(41,377)		69
70	TOTAL (lines 4 thru 69)		$ 5,310,230	$ 182,974		$ 150,696	$ (32,278)	$ 3,797,983	70

**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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,310,230	$ 182,974		$ 150,696	$ (32,278)	$ 3,797,983	1
2	Sprinkler System Work	2013	6,322		20	316	316	1,106	2
3	Walk In Cooler Repair	2015	2,983		20	149	149	162	3
4	Fire Rated Speaker Cover	2016	2,566		20	128	128	128	4
5	Repaired Steam Piping Valves	2016	3,725		20	186	186	186	5
6	Repaired Ac In Lunchroom	2016	2,520		20	126	126	126	6
7	Installed Lead Free Multi Valve	2016	3,031		20	152	152	152	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,331,378	$ 182,974		$ 151,754	$ (31,220)	$ 3,799,843	34

**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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,331,378	$ 182,974		$ 151,754	$ (31,220)	$ 3,799,843	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
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,331,378	$ 182,974		$ 151,754	$ (31,220)	$ 3,799,843	34

**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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 5,331,378	$ 182,974		$ 151,754	$ (31,220)	$ 3,799,843	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
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,331,378	$ 182,974		$ 151,754	$ (31,220)	$ 3,799,843	34

**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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 5,331,378	$ 182,974		$ 151,754	$ (31,220)	$ 3,799,843	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
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,331,378	$ 182,974		$ 151,754	$ (31,220)	$ 3,799,843	34

**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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Various	2008	230,706		20	11,535	11,535	103,815	9
10	Various	2009	571,486		20	24,434	24,434	195,381	10
11	Various	2010	694,673		20	34,734	34,734	264,786	11
12	Grease Interceptor & Floor Drain	2011	7,400		20	370	370	2,220	12
13	Coffee Shop Custom Cabinet	2011	3,000		20	150	150	900	13
14	Duct extensions- community bathrooms	2012	5,321		20	266	266	1,330	14
15	Sprinkler System Repair	2012	3,367		20	168	168	840	15
16	Boiler Repair	2012	3,326		20	166	166	830	16
17	Kitchen-patch walls and paint	2012	3,700		20	185	185	925	17
18	Elevator Generator	2013	5,500		20	275	275	1,100	18
19	Nurse Call Annuciator	2013	8,331		20	417	417	1,668	19
20	Camera Security System	2013	7,230		20	362	362	1,448	20
21	Mounted Firedoor Holders	2015	6,340		20	317	317	634	21
22	Replace Radiant Heat Lines	2015	6,435		20	322	322	644	22
23	Removed and Installed Hot Water Storage Tank -Lower Level	2016	13,950		20	698	698	698	23
24	Valve Replacement	2016	3,319		20	166	166	166	24
25									25
26									26
27	Depreciation			138,054			(138,054)		27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,574,084	$ 138,054		$ 74,564	$ (63,490)	$ 577,385	34

**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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 1,574,084	$ 138,054		$ 74,564	$ (63,490)	$ 577,385	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
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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)		$ 1,574,084	$ 138,054		$ 74,564	$ (63,490)	$ 577,385	34

**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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from SIR Management/Generations HC Network	2009	33,235	852	39	852		6,001	3
4	Allocated from SIR Properties - SIR Management	1993	30,089	955	35	860	(95)	20,202	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from SIR Management/Generations HC Network	1993	7,628	212	20		(212)	7,628	9
10	Allocated from SIR Management/Generations HC Network	1994	24		20			24	10
11	Allocated from SIR Management/Generations HC Network	1995	174		20			174	11
12	Allocated from SIR Management/Generations HC Network	1997	11,722		20	571	571	11,525	12
13	Allocated from SIR Management/Generations HC Network	1999	922		20	46	46	795	13
14	Allocated from SIR Management/Generations HC Network	1999	8,112		20			8,112	14
15	Allocated from SIR Management/Generations HC Network	2000	1,088		20	54	54	900	15
16	Allocated from SIR Management/Generations HC Network	2007	3,496		20	175	175	1,607	16
17	Allocated from SIR Management/Generations HC Network	2008	9,636	964	20	607	(357)	5,372	17
18	Allocated from SIR Management/Generations HC Network	2009	23,943	219	20	1,197	978	8,673	18
19	Allocated from SIR Management/Generations HC Network	2011	592	59	20	59		321	19
20	Allocated from SIR Management/Generations HC Network	2012	1,896	95	20	95		419	20
21	Allocated from SIR Management/Generations HC Network	2014	266	27	20	13	(14)	34	21
22	Allocated from SIR Management/Generations HC Network	2016	346	7	20	7		7	22
23									23
24	Allocated from SIR Properties - SIR Management	2012	1,843	93	20	92	(1)	369	24
25	Allocated from SIR Properties - SIR Management	2010	1,816		20	91	91	575	25
26	Allocated from SIR Properties - SIR Management	2009	1,807	40	20	90	50	705	26
27	Allocated from SIR Properties - SIR Management	2007	527	11	20	26	15	263	27
28	Allocated from SIR Properties - SIR Management	2002	119		20	6	6	87	28
29	Allocated from SIR Properties - SIR Management	1999	3,813		20	191	191	3,336	29
30	Allocated from SIR Properties - SIR Management	1998	1,822		20	91	91	1,685	30
31	Allocated from SIR Properties - SIR Management	1997	113		20	5	5	113	31
32	Allocated from SIR Properties - SIR Management	1994	287	7	20		(7)	287	32
33	Allocated from SIR Properties - SIR Management	1993	488	2	20		(2)	488	33
34	TOTAL (lines 1 thru 33)		$ 145,804	$ 3,543		$ 5,128	$ 1,585	$ 79,702	34

**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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 145,804	$ 3,543		$ 5,128	$ 1,585	$ 79,702	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
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22									22
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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)		$ 145,804	$ 3,543		$ 5,128	$ 1,585	$ 79,702	34

**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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 598,741	$ 30,918	$ 33,079	$ 2,161	10	$ 490,271	71
72	Current Year Purchases	14,964	22	1,456	1,434	10	1,456	72
73	Fully Depreciated Assets	227,859				10	227,859	73
74								74
75	TOTALS	$ 841,564	$ 30,940	$ 34,535	$ 3,595		$ 719,586	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		PASSENGER VAN	2007	$ 14,137	$	$	$	5	$ 14,137	76
77		Allocated from SIR Mgmt/Gener	2016	2,337	204	202	(2)	5	1,798	77
78										78
79										79
80	TOTALS			$ 16,474	$ 204	$ 202	$ (2)		$ 15,935	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)	$ 6,341,971	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 214,118	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 186,491	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (27,627)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,535,365	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.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: *

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 6,835 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	Allocated from SIR Mgmt/Generations HC Network		$	$ 4,300	17
18					18
19					19
20					20
21	TOTAL		$ -	$ 4,300	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.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental									13
14	TOTAL			$		$	$		$	14

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

STATE OF ILLINOIS

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/16 (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	$ 42,551	$ 139,047	1
2	Cash-Patient Deposits	22,141	22,141	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	562,891	562,891	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,579	41,548	6
7	Other Prepaid Expenses	6,639	6,639	7
8	Accounts Receivable (owners or related parties)	200,000	200,000	8
9	Other(specify): See Attached Schedule	2,205	2,205	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 857,006	$ 974,471	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		152,555	13
14	Buildings, at Historical Cost		2,274,062	14
15	Leasehold Improvements, at Historical Cost	1,070,814	2,413,679	15
16	Equipment, at Historical Cost	1,004,593	1,472,742	16
17	Accumulated Depreciation (book methods)	(1,409,360)	(4,103,514)	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):		405,251	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 666,047	$ 2,614,775	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,523,053	$ 3,589,246	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 120,519	$ 120,519	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	22,141	22,141	28
29	Short-Term Notes Payable	120,000	120,000	29
30	Accrued Salaries Payable	148,572	148,572	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,602	8,602	31
32	Accrued Real Estate Taxes(Sch.IX-B)		205,500	32
33	Accrued Interest Payable		32,099	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	14,271	14,271	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 434,105	$ 671,704	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,005,231	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43			694,602	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 11,699,833	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 434,105	$ 12,371,537	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,088,948	$ (8,782,291)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,523,053	$ 3,589,246	48

*(See instructions.)

Facility Name & ID Number Greenwood Care **#** 0031971 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,064,181	1
2	Restatements (describe):		2
3	Rounding	6	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,064,187	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	53,761	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	(29,000)	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)**	$ 24,761	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)**	$ 1,088,948	24 *

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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,310,592	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,310,592	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	117	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)**	$ 117	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	19,602	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 19,602	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	8,303	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,303	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,338,614	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,148,720	31
32	Health Care	1,620,272	32
33	General Administration	1,461,955	33
	B. Capital Expense		
34	Ownership	1,053,906	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,284,853	40
41	**Income before Income Taxes (line 30 minus line 40)****	53,761	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 53,761	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,396,845	44
45	Private Pay - Net Inpatient Revenue	192,432	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Managed Care	2,721,315	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,310,592	49

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

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

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

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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,942	2,072	$ 94,113	$ 45.42	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,526	3,613	91,784	25.40	3
4	Licensed Practical Nurses	11,698	12,571	291,368	23.18	4
5	CNAs & Orderlies	43,758	46,893	515,601	11.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,361	2,810	36,851	13.11	8
9	Activity Director					9
10	Activity Assistants	14,978	15,483	150,595	9.73	10
11	Social Service Workers	12,455	13,780	211,824	15.37	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,219	18,589	201,067	10.82	15
16	Dishwashers					16
17	Maintenance Workers	3,793	4,094	52,948	12.93	17
18	Housekeepers	18,860	20,589	217,769	10.58	18
19	Laundry					19
20	Administrator	1,920	2,091	88,195	42.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,255	14,541	185,028	12.72	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	3,909	4,202	78,747	18.74	31
32	Other Health Care(specify)					32
33	Other(specify)	4,435	4,435	18,289	4.12	33
34	TOTAL (lines 1 - 33)	154,109	165,763	$ 2,234,179 *	$ 13.48	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 26,796	01-03	35
36	Medical Director	Monthly	4,800	09-03	36
37	Medical Records Consultant	Monthly	4,400	10-03	37
38	Nurse Consultant	Monthly	41,760	10-03	38
39	Pharmacist Consultant	Monthly	9,596	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	680	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychiatric Consultant	Monthly	3,600	12-03	47
48	Specialized Rehab	Monthly	24,360	10A-03	48
49	TOTAL (lines 35 - 48)		$ 115,992		49

C. CONTRACT NURSES

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

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Laurie M. Daugherty	Administrator	0.00%	$ 88,195
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 88,195

B. Administrative - Other

Description	Amount
SIR Management- Consulting Fees	$ 265,511
SIR Management- Director of Adminstrative Services	41,760
SIR Management- Ancillary Administrative Charges	34,800
TOTAL (agree to Schedule V, line 17, col. 3)	$ 342,071
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 14,200
Plante Moran	Accounting	1,100
SIR Management	Bookkeeping	64,380
SIR Management	Dir. Of Regulatory Services	20,880
SIR Management	Dir. Of Financial Services	42,000
SIR Management	Director of Admissions	29,580
SIR Management	Director of IT	8,700
SIR Management	Computer Support	19,140
See Attached	Legal Services	3,534
Legat Architects	Architectural Consulting	3,249
Pinnacle Quality Insights	Customer Satisfaction	2,813
See Supplemental Schedule		20,056
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 229,631

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 28,384
Unemployment Compensation Insurance	40,961
FICA Taxes	168,239
Employee Health Insurance	108,924
Employee Meals	20,112
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension Plan	21,214
Life Insurance	1,336
401K Match	3,675
Other Employee Benefits	6,598
TOTAL (agree to Schedule V, line 22, col.8)	$ 399,442

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,992
Advertising: Employee Recruitment	972
Health Care Worker Background Check	2,450
(Indicate # of checks performed 245)	
Patient Background Checks 95	950
Dues and Subscriptions	13,023
License and Permits	10,115
Allocated from SIR Mgmt/Generations HC	1,631
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 31,133

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,177
Allocated from SIR Mgmt/Generations HC	468
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,645

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Greenwood Care # 0031971 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Alliance for Living $18,804**

(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. $ **234** 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. $
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **20,112** 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? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees