		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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0054254

Facility Name: Greenwood Care Ltd.

Address: 1406 N. Chicago Ave. (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 01/01/18 to 12/31/18 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)
** Subject to the attached Accountants' Consulting Report* (Date)
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 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 Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	7,318	1,076	38,765	47,159	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,318	1,076	38,765	47,159	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.11%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 N/A

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

STATE OF ILLINOIS

Facility Name & ID Number Greenwood Care Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	229,735	19,005	22,167	270,907		270,907	(6,516)	264,391			1
2	Food Purchase		253,327		253,327	(20,823)	232,504	(1,257)	231,247			2
3	Housekeeping	259,569	38,981		298,550		298,550	(2,981)	295,569			3
4	Laundry		12,787	13,476	26,263		26,263	(149)	26,114			4
5	Heat and Other Utilities			119,771	119,771		119,771	(13,297)	106,474			5
6	Maintenance	58,315	69,792	183,804	311,911		311,911	2,305	314,216			6
7	Other (specify):*							13,439	13,439			7
8	**TOTAL General Services**	547,619	393,892	339,218	1,280,729	(20,823)	1,259,906	(8,456)	1,251,449			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,227,529	29,745	59,424	1,316,698		1,316,698	(2,870)	1,313,828			10
10a	Therapy	42,373		27,840	70,213		70,213	(9,208)	61,005			10a
11	Activities	151,297	9,948		161,245		161,245		161,245			11
12	Social Services	309,784		6,000	315,784		315,784		315,784			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							9,051	9,051			15
16	**TOTAL Health Care and Programs**	1,730,983	39,693	93,264	1,863,940		1,863,940	(3,027)	1,860,913			16
	C. General Administration											
17	Administrative	82,261		231,581	313,842		313,842	(109,385)	204,457			17
18	Directors Fees											18
19	Professional Services			239,378	239,378	(108)	239,270	(151,744)	87,526			19
20	Dues, Fees, Subscriptions & Promotions			61,428	61,428		61,428	(33,374)	28,054			20
21	Clerical & General Office Expenses	144,363	20,329	52,135	216,827		216,827	94,536	311,363			21
22	Employee Benefits & Payroll Taxes			397,896	397,896	20,823	418,719	(213)	418,507			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,970	3,970		3,970	(1,689)	2,281			24
25	Other Admin. Staff Transportation			4,861	4,861		4,861	14,611	19,472			25
26	Insurance-Prop.Liab.Malpractice			131,966	131,966		131,966	8,872	140,838			26
27	Other (specify):*							31,345	31,345			27
28	**TOTAL General Administration**	226,624	20,329	1,123,215	1,370,168	20,715	1,390,883	(147,041)	1,243,842			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,505,226	453,914	1,555,697	4,514,837	(108)	4,514,729	(158,524)	4,356,205			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 Ltd. #0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			41,149	41,149		41,149	135,614	176,763			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,914	15,914		15,914	308,920	324,834			32
33	Real Estate Taxes					108	108	210,940	211,048			33
34	Rent-Facility & Grounds			996,000	996,000		996,000	(996,000)				34
35	Rent-Equipment & Vehicles			5,724	5,724		5,724	3,449	9,173			35
36	Other (specify):*							58,504	58,504			36
37	**TOTAL Ownership**			1,058,787	1,058,787	108	1,058,895	(278,573)	780,322			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)**	2,505,226	453,914	2,614,484	5,573,624	(0)	5,573,624	(437,097)	5,136,527			45

***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 Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	(15,010)	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	(29,215)	30		9
10	Interest and Other Investment Income	(43,537)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(57)	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	(20,227)	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	(15,000)	21		24
25	Fund Raising, Advertising and Promotional	(3,077)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,355)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(64,074)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (191,552)		$	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)	(245,545)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (245,545)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (437,097)		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 Ltd.

ID# 0054254

Report Period Beginning: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Office Expense - Bank Fees	$ (7,319)	21	1
2	Theft & Damage Loss	(1,312)	21	2
3	Vending Income	(1,200)	02	3
4	Capitalized R&M	(20,374)	06	4
5	Alliance for Living	(10,162)	20	5
6	Non-allowable Seminars	(1,918)	24	6
7	Non-allowable Legal	(5,883)	19	7
8	Bldg Co - Office Expenses	(12)	21	8
9	Bldg Co - Professional Fees	(10,500)	19	9
10	Bldg Co - Amortization	(2,101)	36	10
11	Bldg Co - Capitalized R&M	(3,293)	06	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**	(64,074)		49

Greenwood Care Ltd.

ID# 0054254

Report Period Beginning: 01/01/18

Ending: 12/31/18

	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 Ltd. # 0054254 **Report Period Beginning:** 01/01/18 **Ending:** 12/31/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(6,516)								(6,516)	1
2	Food Purchase	(1,257)											(1,257)	2
3	Housekeeping						(2,981)						(2,981)	3
4	Laundry						(149)						(149)	4
5	Heat and Other Utilities	(15,010)			1,713								(13,297)	5
6	Maintenance	(23,667)	13,661	(948)	13,259								2,305	6
7	Other (specify):*			1,001	12,438								13,439	7
8	**TOTAL General Services**	(39,934)	13,661	53	20,894		(3,130)						(8,456)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(5,754)	6,430	(1,203)	(2,343)						(2,870)	10
10a	Therapy				(9,208)								(9,208)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			4,857	4,194								9,051	15
16	**TOTAL Health Care and Programs**			(897)	1,417	(1,203)	(2,343)						(3,027)	16
	C. General Administration													
17	Administrative			(208,950)	99,565								(109,385)	17
18	Directors Fees													18
19	Professional Services	(16,383)	10,500	(157,933)	12,072								(151,744)	19
20	Fees, Subscriptions & Promotions	(33,466)		92									(33,374)	20
21	Clerical & General Office Expenses	(24,998)	12	119,435	91	(4)							94,536	21
22	Employee Benefits & Payroll Taxes					(213)							(213)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,918)		229									(1,689)	24
25	Other Admin. Staff Transportation			14,611									14,611	25
26	Insurance-Prop.Liab.Malpractice		7,385	1,275	212								8,872	26
27	Other (specify):*			8,041	23,304								31,345	27
28	**TOTAL General Administration**	(76,765)	17,897	(223,200)	135,244	(217)							(147,041)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(116,699)	31,558	(224,044)	157,554	(1,419)	(5,474)						(158,524)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Greenwood Care Ltd. # 0054254 **Report Period Beginning:** 01/01/18 **Ending:** 12/31/18

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	(29,215)	160,226		4,603								135,614	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(43,537)	372,152	(23,867)	4,172								308,920	32
33	Real Estate Taxes		204,310		6,630								210,940	33
34	Rent-Facility & Grounds		(996,000)										(996,000)	34
35	Rent-Equipment & Vehicles			3,449									3,449	35
36	Other (specify):*	(2,101)	60,605										58,504	36
37	**TOTAL Ownership**	(74,853)	(198,707)	(20,418)	15,405								(278,573)	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)**	(191,552)	(167,149)	(244,462)	172,959	(1,419)	(5,474)						(437,097)	45

Facility Name & ID Number Greenwood Care Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$	$ (996,000)	1
2	V	32	Interest	179	Greenwood Care LLC		372,331	372,152	2
3	V	36	Amortization		Greenwood Care LLC		2,101	2,101	3
4	V	06	Repairs and Maintenance		Greenwood Care LLC		13,661	13,661	4
5	V	36	Mortgage Insurance		Greenwood Care LLC		58,504	58,504	5
6	V	21	Office Expense		Greenwood Care LLC		12	12	6
7	V	26	Property Insurance		Greenwood Care LLC		7,385	7,385	7
8	V	33	Real Estate Taxes		Greenwood Care LLC		204,310	204,310	8
9	V	30	Depreciation		Greenwood Care LLC		160,226	160,226	9
10	V	19	Professional Fees		Greenwood Care LLC		10,500	10,500	10
11	V								11
12	V								12
13	V								13
14	Total			$ 996,179			$ 829,030	$ * (167,149)	14

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

Facility Name & ID Number Greenwood Care Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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.	$ 12,180	GENERATIONS HC NETWORK, LLC		$ 11,232	$ (948)	15
16	V	7	EMP. BEN.-GEN. SERV.		GENERATIONS HC NETWORK, LLC		1,001	1,001	16
17	V	9	MEDICAL DIRECTOR CONSULTS		GENERATIONS HC NETWORK, LLC				17
18	V	10	NURSING	34,800	GENERATIONS HC NETWORK, LLC		29,046	(5,754)	18
19	V	15	EMP. BEN.-H.C.		GENERATIONS HC NETWORK, LLC		4,857	4,857	19
20	V	17	ADMINISTRATIVE	231,581	GENERATIONS HC NETWORK, LLC		22,631	(208,950)	20
21	V	19	PROFESSIONAL FEES	166,956	GENERATIONS HC NETWORK, LLC		9,023	(157,933)	21
22	V	20	FEES,SUBSCRIPTIONS		GENERATIONS HC NETWORK, LLC		92	92	22
23	V	21	CLERICAL & GENERAL	7,836	GENERATIONS HC NETWORK, LLC		127,271	119,435	23
24	V	24	EDUCATION & SEMINAR		GENERATIONS HC NETWORK, LLC		229	229	24
25	V	25	OTHER ADMIN. STAFF TRANS.		GENERATIONS HC NETWORK, LLC		14,611	14,611	25
26	V	26	INSURANCE		GENERATIONS HC NETWORK, LLC		1,275	1,275	26
27	V	27	EMP. BEN.-GEN. ADMIN.		GENERATIONS HC NETWORK, LLC		8,041	8,041	27
28	V	32	INTEREST		GENERATIONS HC NETWORK, LLC		(23,867)	(23,867)	28
29	V	35	AUTO RENTAL		GENERATIONS HC NETWORK, LLC		2,782	2,782	29
30	V	35	EQUIPMENT RENTAL		GENERATIONS HC NETWORK, LLC		667	667	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			$ 453,353			$ 208,891	$ * (244,462)	39

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

Facility Name & ID Number Greenwood Care Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	1	DIETARY SALARIES	$ 12,180	GENERATIONS HC NETWORK, LLC		$ 5,664	$ (6,516)	15
16	V	7	EMP. BEN.-DIETARY		GENERATIONS HC NETWORK, LLC		948	948	16
17	V	10	NURSING SALARIES		GENERATIONS HC NETWORK, LLC		6,430	6,430	17
18	V	15	EMP. BEN.-NURSING		GENERATIONS HC NETWORK, LLC		1,070	1,070	18
19	V	17	ADMIN./LEGAL SALARIES		GENERATIONS HC NETWORK, LLC		99,565	99,565	19
20	V	19	FIN. CONSULT./REGL. DIR.		GENERATIONS HC NETWORK, LLC		11,817	11,817	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		GENERATIONS HC NETWORK, LLC		23,304	23,304	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	27,840	GENERATIONS HC NETWORK, LLC		18,632	(9,208)	24
25	V	15	EMPLOYEE BENFITS		GENERATIONS HC NETWORK, LLC		3,124	3,124	25
26	V								26
27	V	6	MAINTENANCE SALARIES	52,808	GENERATIONS HC NETWORK, LLC		65,077	12,269	27
28	V	7	EMPLOYEE BENEFITS		GENERATIONS HC NETWORK, LLC		11,490	11,490	28
29	V								29
30	V	5	UTILITIES		GENERATIONS HC NETWORK, LLC		1,713	1,713	30
31	V	6	REPAIRS AND MAINT.		GENERATIONS HC NETWORK, LLC		990	990	31
32	V	19	PROFESSIONAL FEES		GENERATIONS HC NETWORK, LLC		255	255	32
33	V	21	CLERICAL & GENERAL		GENERATIONS HC NETWORK, LLC		91	91	33
34	V	26	INSURANCE		GENERATIONS HC NETWORK, LLC		212	212	34
35	V	30	DEPRECIATION		GENERATIONS HC NETWORK, LLC		4,603	4,603	35
36	V	32	INTEREST		GENERATIONS HC NETWORK, LLC		4,172	4,172	36
37	V	33	REAL ESTATE TAXES		GENERATIONS HC NETWORK, LLC		6,630	6,630	37
38	V								38
39	Total			$ 92,828			$ 265,787	$ * 172,959	39

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

Facility Name & ID Number Greenwood Care Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	06	Maintenance	$	MAC Rx, LLC		$	$	15
16	V	10	Nursing and Medical Records	13,955	MAC Rx, LLC		12,752	(1,203)	16
17	V	10A	Therapy		MAC Rx, LLC				17
18	V	19	Professional Services		MAC Rx, LLC				18
19	V	21	Clerical & General Office Expenses	47	MAC Rx, LLC		43	(4)	19
20	V	22	Employee Benefits	2,466	MAC Rx, LLC		2,254	(213)	20
21	V	39	Ancillary		MAC Rx, LLC				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			$ 16,468			$ 15,049	$ * (1,419)	39

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

Facility Name & ID Number Greenwood Care Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$	Big Ten Supply, LLC	100.00%	$	$	15
16	V	3	Housekeeping	31,129	Big Ten Supply, LLC	100.00%	28,148	(2,981)	16
17	V	4	Laundry	1,559	Big Ten Supply, LLC	100.00%	1,409	(149)	17
18	V	6	Repairs & Maintenance		Big Ten Supply, LLC	100.00%			18
19	V	10	Nursing And Medical Records	24,472	Big Ten Supply, LLC	100.00%	22,129	(2,343)	19
20	V	10A	Therapy		Big Ten Supply, LLC	100.00%			20
21	V	21	Clerical & General		Big Ten Supply, LLC	100.00%			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			$ 57,160			$ 51,686	$ * (5,474)	39

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

Facility Name & ID Number Greenwood Care Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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%	AUBURN VILLAGE	AUBURN, IN	GREENWOOD CARE LLC	EVANSTON	BUILDING CO.	1
2	DENNIS TOSSI	2.76%	ALBANY CARE, INC.	EVANSTON	GENERATIONS HEALTH NETW	LINCOLNWOOD	CONSULTING CO.	2
3	LOUISE BERGTHOLD	3.45%	BRYN MAWR CARE INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	THOMAS & STEPHANIE WINTER REV. TRUST	4.14%	DECATUR MANOR HEALTHCARE,LLC	DECATUR	OAKTON ARMS	DES PLAINES	ASSISTED LIVING	4
5	MICHAEL R. GIANNINI TRUST DTD 3/13/00	3.45%	GENERATIONS AT APPLEWOOD, LLC	MATTESON	MAC Rx LLC	DES PLAINES	PHARMACY CONS	5
6	CELESTE GIANNINI TRUST DTD 3/13/00	3.45%	GENERATIONS AT COLUMBUS PARK, INC	CHICAGO	BIG TEN SUPPLY, LLC	LIBERTYVILLE	SUPPLY CO.	6
7	JULIANA R BARRISH TRUST DTD 1/26/93	15.52%	GENERATIONS AT ELMWOOD PARK, INC	ELMWOOD PARK				7
8	BRYAN BARRISH TRUST DTD 9/01/04	15.52%	GENERATIONS AT NEIGHBORS, LLC	BYRON				8
9			GENERATIONS AT OAKTON PAVILION, LLC	DES PLAINES				9
10			GENERATIONS AT REGENCY, LLC	NILES				10
11			GENERATIONS AT ROCK ISLAND, LLC	ROCK ISLAND				11
12			WILSON CARE, INC.	CHICAGO				12
13			GENERATIONS AT LINCOLN, LLC	LINCOLN				13
14			GENERATIONS AT MCKINLEY COURT, LLC	DECATUR				14
15			GENERATIONS AT MCKINLEY PLACE, LLC	DECATUR				15
16			GENERATIONS AT PEORIA, LLC	PEORIA				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 Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	2.03	5.07%	Alloc. Salary	$ 14,494	17-7	1
2	Kirsten Schloss	Relative	Maintenance		See Attached	2.32	5.80%	Alloc. Salary	5,979	6-7	2
3	Sarah Barrish	Relative	Administrative		See Attached	2.9	5.80%	Alloc. Salary	7,290	17-7	3
4	Louise Bergthold	Owner	Administrative	3.45%	See Attached	3.48	5.80%	Alloc. Salary	14,494	17-7	4
5	Michael Giannini	Relative	Administrative		See Attached	2.03	5.07%	Alloc. Salary	10,482	17-7	5
6	Nenita Guzman	Relative	Dietary		See Attached	2.9	5.80%	Alloc. Salary	5,664	1-7	6
7	Tom Winter	Owner	Administrative	4.14%	See Attached	3.48	5.80%	Alloc. Salary	14,494	17-7	7
8	Thomas Bergthold	Relative	Clerical		See Attached	2.32	5.80%	Alloc. Salary	2,867	21-7	8
9	Clark Collins	Relative	Administrative		See Attached	0.81	2.02%	Alloc. Salary	1,011	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	$ 76,775		13

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

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

Facility Name & ID Number Greenwood Care Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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: GENERATIONS HC NETWORK, LLC
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	813,429	20	$ 193,743	$ 103,385	47,159	$ 11,232	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	813,429	20	17,260		47,159	1,001	2
3	9	MEDICAL DIRECTOR CONSUL	PATIENT DAYS	813,429	20			47,159		3
4	10	NURSING	PATIENT DAYS	813,429	20	501,001	501,001	47,159	29,046	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	813,429	20	83,773		47,159	4,857	5
6	17	ADMINISTRATIVE	PATIENT DAYS	813,429	20	390,351	390,351	47,159	22,631	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	813,429	20	155,641		47,159	9,023	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	813,429	20	1,590		47,159	92	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	813,429	20	2,195,251	1,959,905	47,159	127,271	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	813,429	20	3,956		47,159	229	10
11	25	OTHER ADMIN. STAFF TRANS.	PATIENT DAYS	813,429	20	252,011		47,159	14,611	11
12	26	INSURANCE	PATIENT DAYS	813,429	20	21,989		47,159	1,275	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	813,429	20	138,692		47,159	8,041	13
14	32	INTEREST	PATIENT DAYS	813,429	20	(411,674)		47,159	(23,867)	14
15	35	AUTO RENTAL	PATIENT DAYS	813,429	20	47,983		47,159	2,782	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	813,429	20	11,512		47,159	667	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,603,079	$ 2,954,641		$ 208,891	25

Facility Name & ID Number Greenwood Care Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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: GENERATIONS HC NETWORK, LLC
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	813,429	20	$ 97,690	$ 97,690	47,159	$ 5,664	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	813,429	20	16,359		47,159	948	2
3	10	NURSING SALARIES	PATIENT DAYS	813,429	20	110,913	110,913	47,159	6,430	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	813,429	20	18,452		47,159	1,070	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	813,429	20	1,717,366	1,717,366	47,159	99,565	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	813,429	20	203,820		47,159	11,817	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	813,429	20	401,962		47,159	23,304	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	284,688	14	190,531	190,531	27,840	18,632	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	284,688	14	31,950		27,840	3,124	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	368,277	19	453,836	453,836	52,808	65,077	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	368,277	19	80,131		52,808	11,490	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	20	29,526		747	1,713	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	20	17,073		747	990	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	20	4,403		747	255	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	20	1,572		747	91	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	20	3,650		747	212	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	20	79,352		747	4,603	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	20	71,924		747	4,172	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	20	114,307		747	6,630	23
24										24
25	TOTALS					$ 3,644,817	$ 2,570,336		$ 265,787	25

Facility Name & ID Number Greenwood Care Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	06	Maintenance	Direct Allocation			$	$		$	1
2	10	Nursing And Medical Records	Direct Allocation						12,752	2
3	10A	Therapy	Direct Allocation							3
4	19	Professional Services	Direct Allocation							4
5	21	Clerical & General Office Expense	Direct Allocation						43	5
6	22	Employee Benefits	Direct Allocation						2,254	6
7	39	Ancillary	Direct Allocation							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					$	$		$ 15,049	25

Facility Name & ID Number Greenwood Care Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	1	Dietary	Direct Allocation			$	$		$	1
2	3	Housekeeping	Direct Allocation						28,148	2
3	4	Laundry	Direct Allocation						1,409	3
4	6	Repairs & Maintenance	Direct Allocation							4
5	10	Nursing And Medical Records	Direct Allocation						22,129	5
6	10A	Therapy	Direct Allocation							6
7	21	Clerical & General	Direct Allocation							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					$	$		$ 51,686	25

Facility Name & ID Number Greenwood Care Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Greenwood Care Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Greenwood Care Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Greenwood Care Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Greenwood Care Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Greenwood Care Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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** 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	The Private Bank		X	Mortgage			$	$ 10,525,441			$ 372,331	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Lake Forest Bank		X	Line of Credit				460,000			15,914	6
7												7
8												8
9	TOTAL Facility Related						$	$ 10,985,441			$ 388,245	9
	B. Non-Facility Related*											
10	Interest Income		X								(43,537)	10
11	Interest Income - Bldg Co		X								(179)	11
12	Allocated from Generations HC		X								(19,695)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (63,411)	14
15	TOTALS (line 9+line14)						$	$ 10,985,441			$ 324,834	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 58,504 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 Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 193,000	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.)		$ 200,440	2
3. Under or (over) accrual (line 2 minus line 1).		$ 7,440	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 203,500	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.)**		$ 108	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 $ 125 For 2014 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.		$ 211,048	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	193,972	8
	2014	193,911	9
	2015	195,773	10
	2016	183,824	11
	2017	193,810	12

2018 Accrual: $193,810 x 1.05 = $203,500 (Rounded)

Allocated from Generations HC Network LLC: $6,630

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Greenwood Care Ltd. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054254

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(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	$ 193,809.84	$ 193,809.84
2.	See Attached	Allocated from SIR	$ 137,812.17	$ 6,260.00
3.	See Attached	Allocated from Regency	$ 899,389.48	$ 316.91
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,231,011.49	$ 200,386.75

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 2017 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 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Greenwood Care Ltd. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054254

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	2,489	9
10	Various			1987	24,869		20	694	694	23,287	10
11	Various			1988	27,733		20	321	321	21,603	11
12	Various			1989	7,668		20	87	87	6,114	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			109,218	18
19	Various			1997	73,171		20			73,167	19
20	Various			1998	58,371		20	1,519	1,519	58,370	20
21	Various			1999	179,834		20	9,099	9,099	174,406	21
22	Various			2000	171,876		20	8,594	8,594	160,778	22
23	Various			2001	43,730		20	2,186	2,186	38,254	23
24	Various			2002	87,606		20	3,432	3,432	75,039	24
25	Various			2003	59,109		20	1,707	1,707	50,938	25
26	Various			2004	77,107		20	3,144	3,144	60,260	26
27	Various			2005	58,861		20	2,618	2,618	41,762	27
28	Various			2006	271,462		20	13,574	13,574	170,311	28
29	Various			2007	153,877		20	7,339	7,339	92,750	29
30	Various			2008	29,039		20	1,453	1,453	15,129	30
31	Various			2009	36,735		20	1,837	1,837	17,615	31
32	Various			2010	11,568		20	1,157	1,157	9,351	32
33	Various			2011	11,264		20	826	826	6,490	33
34	Various			2012	56,176		20	3,138	3,138	20,846	34
35	Various			2013	6,322		20	316	316	1,739	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 Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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)		1,586,503	160,226		79,325	(80,901)	731,734	67
68	Related Party Allocations (Pages 12H & 12I)		111,766	2,252		3,297	1,044	73,225	68
69	Financial Statement Depreciation			41,149			(41,149)		69
70	TOTAL (lines 4 thru 69)		$ 5,294,933	$ 203,627		$ 145,739	$ (57,888)	$ 4,072,689	70

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

Facility Name & ID Number Greenwood Care Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 5,294,933	$ 203,627		$ 145,739	$ (57,888)	$ 4,072,689	1
2	Walk In Cooler Repair	2015	2,983		20	149	149	460	2
3	Fire Rated Speaker Cover	2016	2,566		20	128	128	385	3
4	Repaired Steam Piping Valves	2016	3,725		20	186	186	543	4
5	Repaired A/C In Lunchroom	2016	2,520		20	126	126	315	5
6	Installed Lead Free Multi Valve	2016	3,031		20	152	152	366	6
7	Repaired Plumbing Pipes In Room 204/2Nd Flr Bath	2017	4,400		20	220	220	385	7
8	Remove And Replace Concrete	2018	6,750		20	169	169	169	8
9	Boiler System Repairs	2018	4,597		20	230	230	230	9
10	Fire Pump Repairs	2018	2,544		20	127	127	127	10
11	Fire Alarm System Upgrade	2018	4,249		20	212	212	212	11
12	Repaired Boiler System	2018	4,597		20	230	230	230	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)		$ 5,336,895	$ 203,627		$ 147,668	$ (55,959)	$ 4,076,111	34

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

Facility Name & ID Number Greenwood Care Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 5,336,895	$ 203,627		$ 147,668	$ (55,959)	$ 4,076,111	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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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)		$ 5,336,895	$ 203,627		$ 147,668	$ (55,959)	$ 4,076,111	34

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

Facility Name & ID Number Greenwood Care Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 5,336,895	$ 203,627		$ 147,668	$ (55,959)	$ 4,076,111	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		$ 5,336,895	$ 203,627		$ 147,668	$ (55,959)	$ 4,076,111	34

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

Facility Name & ID Number Greenwood Care Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 5,336,895	$ 203,627		$ 147,668	$ (55,959)	$ 4,076,111	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,336,895	$ 203,627		$ 147,668	$ (55,959)	$ 4,076,111	34

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

Facility Name & ID Number Greenwood Care Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	126,888	9
10	Various	2009	571,486		20	28,574	28,574	248,389	10
11	Various	2010	694,673		20	34,734	34,734	334,254	11
12	Grease Interceptor & Floor Drain	2011	7,400		20	370	370	2,960	12
13	Coffee Shop Custom Cabinet	2011	3,000		20	150	150	1,200	13
14	Duct extensions- community bathrooms	2012	5,321		20	266	266	1,862	14
15	Sprinkler System Repair	2012	3,367		20	168	168	1,176	15
16	Boiler Repair	2012	3,326		20	166	166	1,162	16
17	Kitchen-patch walls and paint	2012	3,700		20	185	185	1,295	17
18	Elevator Generator	2013	5,500		20	275	275	1,650	18
19	Nurse Call Annuciator	2013	8,331		20	417	417	2,502	19
20	Camera Security System	2013	7,230		20	362	362	2,172	20
21	Mounted Firedoor Holders	2015	6,340		20	317	317	1,268	21
22	Replace Radiant Heat Lines	2015	6,435		20	322	322	1,288	22
23	Removed and Installed Hot Water Storage Tank -Lower Level	2016	13,950		20	698	698	2,094	23
24	Valve Replacement	2016	3,319		20	166	166	498	24
25	HVAC Heat Pump Unit	2017	9,126		20	456	456	912	25
26	15 Air Conditioners	2018	3,293		20	165	165	165	26
27									27
28	Depreciation			160,226			(160,226)		28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,586,503	$ 160,226		$ 79,325	$ (80,901)	$ 731,734	34

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

Facility Name & ID Number Greenwood Care Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 1,586,503	$ 160,226		$ 79,325	$ (80,901)	$ 731,734	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,586,503	$ 160,226		$ 79,325	$	$ 731,734	34

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

Facility Name & ID Number Greenwood Care Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Generations Healthcare Network, LLC	2009	14,500	391	39	372	(19)	3,362	3
4	Allocated from S.I.R. Properties/GHN	1993	26,255	833	35	750	(83)	19,128	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Generations Healthcare Network, LLC	1993	6,657	185	20		(185)	6,657	9
10	Allocated from Generations Healthcare Network, LLC	1994	21		20			21	10
11	Allocated from Generations Healthcare Network, LLC	1995	152		20			152	11
12	Allocated from Generations Healthcare Network, LLC	1997	10,228	229	20		(229)	10,228	12
13	Allocated from Generations Healthcare Network, LLC	1999	804		20	40	40	774	13
14	Allocated from Generations Healthcare Network, LLC	1999	8,112		20			8,112	14
15	Allocated from Generations Healthcare Network, LLC	2000	950		20	47	47	880	15
16	Allocated from Generations Healthcare Network, LLC	2007	3,051		20	153	153	1,708	16
17	Allocated from Generations Healthcare Network, LLC	2008	8,408	161	20	311	149	5,528	17
18	Allocated from Generations Healthcare Network, LLC	2009	20,893	191	20	1,045	854	9,657	18
19	Allocated from Generations Healthcare Network, LLC	2011	517	52	20	52		383	19
20	Allocated from Generations Healthcare Network, LLC	2012	1,654	83	20	83		531	20
21	Allocated from Generations Healthcare Network, LLC	2014	232	23	20	12	(12)	53	21
22	Allocated from Generations Healthcare Network, LLC	2016	302	15	20	15		36	22
23	Allocated from Generations Healthcare Network, LLC	2018							23
24									24
25	Allocated from S.I.R. Properties/GHN	2012	1,608	70	20	80	10	483	25
26	Allocated from S.I.R. Properties/GHN	2010	1,584		20	79	79	660	26
27	Allocated from S.I.R. Properties/GHN	2009	1,576		20	79	79	772	27
28	Allocated from S.I.R. Properties/GHN	2007	155	9	20	8	(1)	93	28
29	Allocated from S.I.R. Properties/GHN	2002	104		20	5	5	86	29
30	Allocated from S.I.R. Properties/GHN	1999	3,327		20	166	166	3,244	30
31	Allocated from S.I.R. Properties/GHN	1994	250	6	20		(6)	250	31
32	Allocated from S.I.R. Properties/GHN	1993	426	2	20		(2)	426	32
33									33
34	TOTAL (lines 1 thru 33)		$ 111,766	$ 2,252		$ 3,297	$ 1,044	$ 73,225	34

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

Facility Name & ID Number Greenwood Care Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 111,766	$ 2,252		$ 3,297	$ 1,044	$ 73,225	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
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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)		$ 111,766	$ 2,252		$ 3,297	$ 1,044	$ 73,225	34

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

Facility Name & ID Number Greenwood Care Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 429,617	$ 2,029	$ 27,900	$ 25,871	10	$ 364,153	71
72	Current Year Purchases	4,973	47	481	434	10	481	72
73	Fully Depreciated Assets	405,119		385	385	10	405,119	73
74								74
75	TOTALS	$ 839,709	$ 2,075	$ 28,765	$ 26,690		$ 769,753	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 Generations Healtl	2018	4,369	275	329	54	5	2,032	77
78										78
79										79
80	TOTALS			$ 18,506	$ 275	$ 329	$ 54		$ 16,169	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)	$ 6,347,665	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 205,977	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 176,762	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (29,215)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,862,033	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 Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 6,390 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 Generations HC Network		$	$ 2,782	17
18					18
19					19
20					20
21	TOTAL		$	$ 2,782	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 Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

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):									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 Ltd. # 0054254 Report Period Beginning: 01/01/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/18 (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	$ 2,144	$ 79,778	1
2	Cash-Patient Deposits	46,447	46,447	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	771,123	771,123	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,081	25,050	6
7	Other Prepaid Expenses	3,631	3,631	7
8	Accounts Receivable (owners or related parties)	950,000	950,000	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,778,426	$ 1,876,029	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	1,077,564	2,429,555	15
16	Equipment, at Historical Cost	1,004,593	1,472,742	16
17	Accumulated Depreciation (book methods)	(1,492,048)	(4,512,671)	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): See Attached Schedule		454,305	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 590,109	$ 2,270,548	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,368,535	$ 4,146,577	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 309,679	$ 309,678	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	46,507	46,507	28
29	Short-Term Notes Payable	460,000	460,000	29
30	Accrued Salaries Payable	178,932	178,932	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,334	9,334	31
32	Accrued Real Estate Taxes(Sch.IX-B)		203,500	32
33	Accrued Interest Payable		30,699	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	346,095	346,095	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,350,547	$ 1,584,745	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		10,525,441	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule		623,388	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 11,148,829	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,350,547	$ 12,733,574	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,017,988	$ (8,586,997)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,368,535	$ 4,146,577	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 856,023	1	
2	Restatements (describe):		2	
3	**Prior Year Capital Contributions**	116,000	3	
4	**Rounding**	2	4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 972,025	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	45,963	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	( )	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)**	$ 45,963	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)**	$ 1,017,988	24	*

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

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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	$ 5,574,725	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,574,725	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	44,737	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 44,737	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	125	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 125	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,619,587	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,280,729	31
32	Health Care	1,863,940	32
33	General Administration	1,370,168	33
	B. Capital Expense		
34	Ownership	1,058,787	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)***	$ 5,573,624	40
41	**Income before Income Taxes (line 30 minus line 40)****	45,963	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 45,963	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 863,311	44
45	Private Pay - Net Inpatient Revenue	145,268	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Managed Care	4,566,146	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,574,725	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Completed 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.**

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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	1,765	2,069	$ 93,303	$ 45.10	1
2	Assistant Director of Nursing	2,445	2,670	72,644	27.21	2
3	Registered Nurses	2,099	2,264	56,756	25.07	3
4	Licensed Practical Nurses	11,682	12,449	303,524	24.38	4
5	CNAs & Orderlies	44,508	48,613	675,743	13.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,719	2,981	42,373	14.21	8
9	Activity Director					9
10	Activity Assistants	12,465	13,271	151,297	11.40	10
11	Social Service Workers	16,517	18,266	295,422	16.17	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,566	17,858	229,735	12.86	15
16	Dishwashers					16
17	Maintenance Workers	3,502	4,077	58,315	14.30	17
18	Housekeepers	18,084	19,975	259,569	12.99	18
19	Laundry					19
20	Administrator	1,639	1,852	82,261	44.42	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,294	10,411	144,363	13.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,827	2,055	25,559	12.44	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	2,748	2,748	14,362	5.23	33
34	TOTAL (lines 1 - 33)	147,860	161,559	$ 2,505,226 *	$ 15.51	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	$ 22,167	01-03	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	34,800	10-03	38
39	Pharmacist Consultant	Monthly	10,886	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychiatric Consultant	Monthly	6,000	12-03	47
48	Specialized Rehab	Monthly	27,840	10A-03	48
49	TOTAL (lines 35 - 48)		$ 101,693		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	325	$ 13,738	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	325	$ 13,738		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Laurie Daugherty	Administrator	0.00%	$ 82,261
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 82,261

B. Administrative - Other

Description	Amount
SIR/Generations HN - Consulting Fees	$ 139,361
SIR/Generations HN - Director of Adminstrative Services	48,720
SIR/Generations HN - Ancillary Administrative Charges	43,500
TOTAL (agree to Schedule V, line 17, col. 3)	$ 231,581
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 15,050
RSM US LLP	Accounting	1,950
Plante & Moran PLLC	Accounting	1,125
SIR/Generations HN	Bookkeeping	69,600
SIR/Generations HN	Dir. Of Regulatory Services	15,660
SIR/Generations HN	Dir. Of Financial Services	36,456
Personnel Planners	Unemployment Tax Consultant	1,394
SIR/Generations HN	Director of IT	10,440
SIR/Generations HN	Computer Support	22,620
Pinnacle Quality Insights	Customer Satisfaction	2,656
Paychex	Payroll Processing	15,799
See Supplemental Schedule		46,629
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 239,379

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 30,925
Unemployment Compensation Insurance	11,326
FICA Taxes	188,775
Employee Health Insurance	129,044
Employee Meals	20,823
Illinois Municipal Retirement Fund (IMRF)*	
Employee Insurance - Life	1,673
Employee Benefits - Other	7,230
401K Matching Contr.	3,700
Union Pension Plan	25,011
TOTAL (agree to Schedule V, line 22, col.8)	$ 418,507

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,896
Advertising: Employee Recruitment	4,288
Health Care Worker Background Check	
(Indicate # of checks performed 66)	
Patient Background Checks	660
Dues & Subscriptions	10,823
Licenses & Permits	10,295
Allocated from Generations HC Network	92
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,054

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,052
Allocated from Generations HC Network	229
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,281

**See instructions.

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **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. $ **740** 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. $ **20,823** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
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