		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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0054254

Facility Name: Greenwood Care

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

County: Cook

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

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
[ ]	Charitable Corp.	[X]	(Proprietary)	[ ]	(Governmental)
[ ]	Trust	[ ]	Individual	[ ]	State
	IRS Exemption Code	[ ]	Partnership	[ ]	County
		[ ]	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 01/01/20 to 12/31/20 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) 05/20/21 (Date)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title) Steven N. Lavenda, CPA, Partner
(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 # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	46,572	552		47,124	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	46,572	552		47,124	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.80%

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 N/A 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: 12/31/2019 Fiscal Year: 12/31/2019

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

Facility Name & ID Number Greenwood Care # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	306,879	25,991	31,238	364,108		364,108	(15,097)	349,011			1
2	Food Purchase		253,941		253,941	(21,008)	232,933	(3,885)	229,048			2
3	Housekeeping	340,663	30,863		371,526		371,526	(2,750)	368,776			3
4	Laundry		9,983	15,465	25,448		25,448		25,448			4
5	Heat and Other Utilities			116,399	116,399		116,399	(15,088)	101,311			5
6	Maintenance	40,238	43,116	118,622	201,976		201,976	7,788	209,764			6
7	Other (specify):*							6,647	6,647			7
8	**TOTAL General Services**	687,780	363,894	281,724	1,333,398	(21,008)	1,312,390	(22,385)	1,290,005			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,444,624	59,501	74,319	1,578,444		1,578,444	(6,862)	1,571,582			10
10a	Therapy	42,103			42,103		42,103		42,103			10a
11	Activities	226,203	9,868		236,071		236,071		236,071			11
12	Social Services	270,283		6,000	276,283		276,283		276,283			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							11,577	11,577			15
16	**TOTAL Health Care and Programs**	1,983,213	69,369	80,319	2,132,901		2,132,901	4,715	2,137,616			16
	C. General Administration											
17	Administrative	83,727		351,665	435,392		435,392	(210,978)	224,414			17
18	Directors Fees											18
19	Professional Services			359,073	359,073	(22,627)	336,446	(218,434)	118,012			19
20	Dues, Fees, Subscriptions & Promotions			71,450	71,450		71,450	(30,604)	40,846			20
21	Clerical & General Office Expenses	176,104	37,966	56,572	270,642		270,642	208,596	479,238			21
22	Employee Benefits & Payroll Taxes			497,024	497,024	21,008	518,032	(160)	517,872			22
23	Inservice Training & Education											23
24	Travel and Seminar			128	128		128	356	484			24
25	Other Admin. Staff Transportation			2,546	2,546		2,546	6,384	8,930			25
26	Insurance-Prop.Liab.Malpractice			105,349	105,349		105,349	11,049	116,398			26
27	Other (specify):*							48,554	48,554			27
28	**TOTAL General Administration**	259,831	37,966	1,443,807	1,741,604	(1,618)	1,739,986	(185,238)	1,554,748			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,930,824	471,229	1,805,850	5,207,903	(22,627)	5,185,276	(202,907)	4,982,369			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.

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			35,822	35,822		35,822	122,509	158,331			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,119	15,119		15,119	272,213	287,332			32
33	Real Estate Taxes			53,801	53,801	22,627	76,428	169,723	246,151			33
34	Rent-Facility & Grounds			978,000	978,000		978,000	(978,000)				34
35	Rent-Equipment & Vehicles			6,722	6,722		6,722	4,665	11,387			35
36	Other (specify):*							55,721	55,721			36
37	**TOTAL Ownership**			1,089,464	1,089,464	22,627	1,112,091	(353,169)	758,922			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)**	2,930,824	471,229	2,895,314	6,297,367		6,297,367	(556,077)	5,741,290			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 # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	(16,667)	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	(19,838)	30		9
10	Interest and Other Investment Income	(39,149)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(30)	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	(18,400)	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	(10,417)	21		24
25	Fund Raising, Advertising and Promotional	(2,873)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,500)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(59,715)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (168,589)		$	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)	(387,488)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (387,488)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (556,077)		37

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

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

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

Greenwood Care

ID# 0054254

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Charges	$ (11,681)	21	1
2	Annual Report	(106)	20	2
3	Building Co - Replacement Tax	(4,000)	21	3
4	Building Co - Amortization	(2,101)	36	4
5	Non Allowable Legal	(16,112)	19	5
6	Vending & Cafe Income	(1,200)	02	6
7	Jury Duty	(66)	10	7
8	Building Co - Professional Fees	(11,900)	19	8
9	Lake Forest Bank - Line of Credit	(250)	20	9
10	PAC Dues	(11,766)	20	10
11	Building Co Filing Fees and Office Expense	(533)	21	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**	(59,715)		49

Detail lines 29 and 35 of Page 5 starting in C12. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 5B**

Greenwood Care

ID# 0054254
Report Period Beginning: 01/01/20
Ending: 12/31/20

	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

Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Greenwood Care # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	**5 & 5A**	**6**	**6A**	**6B**	**6C**	**6D**	**6E**	**6F**	**6G**	**6H**	**6I**	**(to Sch V, col.7)**	
1	Dietary				(15,001)		(96)						(15,097)	1
2	Food Purchase	(1,230)		(2,655)									(3,885)	2
3	Housekeeping						(2,750)						(2,750)	3
4	Laundry													4
5	Heat and Other Utilities	(16,667)			1,579								(15,088)	5
6	Maintenance		8,718	(2,732)	2,015		(214)						7,788	6
7	Other (specify):*			1,630	5,017								6,647	7
8	**TOTAL General Services**	(17,897)	8,718	(3,757)	(6,390)		(3,059)						(22,385)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(66)		(2,346)		(1,106)	(3,344)						(6,862)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			11,577									11,577	15
16	**TOTAL Health Care and Programs**	(66)		9,231		(1,106)	(3,344)						4,715	16
	C. General Administration													
17	Administrative			(329,537)	118,559								(210,978)	17
18	Directors Fees													18
19	Professional Services	(28,012)	11,900	(214,538)	12,216								(218,434)	19
20	Fees, Subscriptions & Promotions	(33,395)		2,791									(30,604)	20
21	Clerical & General Office Expenses	(28,131)	4,533	232,102	99	(7)							208,596	21
22	Employee Benefits & Payroll Taxes					(160)							(160)	22
23	Inservice Training & Education													23
24	Travel and Seminar			356									356	24
25	Other Admin. Staff Transportation			6,384									6,384	25
26	Insurance-Prop.Liab.Malpractice		9,020	1,836	193								11,049	26
27	Other (specify):*			21,065	27,489								48,554	27
28	**TOTAL General Administration**	(89,538)	25,453	(279,541)	158,556	(167)							(185,238)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(107,501)	34,171	(274,067)	152,166	(1,273)	(6,403)						(202,907)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Greenwood Care # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	(19,838)	138,318		4,029								122,509	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(39,149)	310,016	(1,577)	2,923								272,213	32
33	Real Estate Taxes		162,718		7,005								169,723	33
34	Rent-Facility & Grounds		(978,000)										(978,000)	34
35	Rent-Equipment & Vehicles			4,665									4,665	35
36	Other (specify):*	(2,101)	57,822										55,721	36
37	**TOTAL Ownership**	(61,088)	(309,126)	3,088	13,957								(353,169)	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)**	(168,589)	(274,955)	(270,979)	166,123	(1,273)	(6,403)						(556,077)	45

Facility Name & ID Number Greenwood Care # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Income	$ 978,000	Greenwood Care LLC		$	$ (978,000)	1
2	V	21	Filing Fees & Office Expense		Greenwood Care LLC		533	533	2
3	V	32	Interest - Mortgage		Greenwood Care LLC		310,090	310,090	3
4	V	36	Mortgage Insurance		Greenwood Care LLC		55,721	55,721	4
5	V	21	Replacement Tax		Greenwood Care LLC		4,000	4,000	5
6	V	19	Professional Fees		Greenwood Care LLC		11,900	11,900	6
7	V	26	Property Insurance		Greenwood Care LLC		9,020	9,020	7
8	V	33	Real Estate Taxes-Current Year		Greenwood Care LLC		217,950	217,950	8
9	V	33	Real Estate Taxes-Prior	55,232	Greenwood Care LLC			(55,232)	9
10	V	06	Repairs - Building & Equipment		Greenwood Care LLC		8,718	8,718	10
11	V	32	Interest Income	74				(74)	11
12	V	30	Depr. - Base		Greenwood Care LLC		138,318	138,318	12
13	V	36	Amort. of HUD Fees		Greenwood Care LLC		2,101	2,101	13
14	Total			$ 1,033,306			$ 758,350	$ * (274,955)	14

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

STATE OF ILLINOIS

Page 6-Supplemental

Facility Name & ID Number Greenwood Care # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	50.16%	ALBANY CARE, INC.	EVANSTON	GREENWOOD CARE LLC	LINCOLNWOOD	BUILDING CO.	1
2	DENNIS TOSSI	2.76%	AUBURN VILLAGE	AUBURN, IN	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	5.70%	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	5
6	CELESTE GIANNINI TRUST DTD 3/13/00	3.45%	GENERATIONS AT ELMWOOD PARK, INC	ELMWOOD PARK	BIG TEN SUPPLY, LLC	LIBERTYVILLE	SUPPLY CO.	6
7	JULIANA R BARRISH TRUST DTD 1/26/93	15.52%	GENERATIONS AT LINCOLN, LLC	LINCOLN	TRANSITIONS INDIANA	HUNTLEY	HOSPICE	7
8	BRYAN BARRISH TRUST DTD 9/01/04	15.52%	GENERATIONS AT NEIGHBORS, LLC	BYRON	GENERATIONS AT RIVERVIEW		ASSISTED & INDEPENDENT	8
9			GENERATIONS AT OAKTON PAVILION, LLC	DES PLAINES	SENIOR LIVING	EAST PEORIA	LIVING	9
10			GENERATIONS AT PEORIA, LLC	PEORIA				10
11			GENERATIONS AT REGENCY, LLC	NILES				11
12			GENERATIONS AT RIVERVIEW, LLC	EAST PEORIA				12
13			GENERATIONS AT ROCK ISLAND, LLC	ROCK ISLAND				13
14			PRAIRIE CREEK VILLAGE, LLC	DECATUR				14
15			VILLA CLARA POST ACUTE, LLC	DECATUR				15
16			WILSON CARE, INC.	CHICAGO				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 # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	2	Dietary Other and Rebates	$	Generations HC Network, LLC		$ (2,655)	$ (2,655)	15
16	V	6	Repairs & Maintanence	15,660	Generations HC Network, LLC		12,928	(2,732)	16
17	V	7	Emp. Ben. - General Svc.		Generations HC Network, LLC		1,630	1,630	17
18	V	9	Medical Director Consults		Generations HC Network, LLC				18
19	V	10	Nursing	64,380	Generations HC Network, LLC		62,034	(2,346)	19
20	V	15	Emp. Ben. - Health Care		Generations HC Network, LLC		11,577	11,577	20
21	V	17	Administrative	349,220	Generations HC Network, LLC		19,683	(329,537)	21
22	V	19	Professional Fees	222,396	Generations HC Network, LLC		7,858	(214,538)	22
23	V	20	Fee, Subscriptions		Generations HC Network, LLC		2,791	2,791	23
24	V	21	Clerical & General	7,836	Generations HC Network, LLC		239,938	232,102	24
25	V	24	Education & Seminar		Generations HC Network, LLC		356	356	25
26	V	25	Other Admin. Staff Transportation		Generations HC Network, LLC		6,384	6,384	26
27	V	26	Insurance		Generations HC Network, LLC		1,836	1,836	27
28	V	27	Emp. Ben. - Gen. Admin.		Generations HC Network, LLC		21,065	21,065	28
29	V	32	Interest		Generations HC Network, LLC		(1,577)	(1,577)	29
30	V	35	Auto Rental		Generations HC Network, LLC		3,964	3,964	30
31	V	35	Equipment Rental		Generations HC Network, LLC		701	701	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 659,492			$ 388,513	$ * (270,979)	39

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

Facility Name & ID Number Greenwood Care # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary Salaries	$ 20,880	Generations HC Network, LLC		$ 5,879	$ (15,001)	15
16	V	7	Emp. Ben. - Dietary		Generations HC Network, LLC		1,099	1,099	16
17	V	17	Admin./Legal Salaries		Generations HC Network, LLC		118,559	118,559	17
18	V	19	Fin. Consult./Regl. Dir.		Generations HC Network, LLC		11,831	11,831	18
19	V	27	Emp. Ben. - Administrative		Generations HC Network, LLC		27,489	27,489	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V	6	Maintenance Salaries	19,530	Generations HC Network, LLC		20,184	654	25
26	V	7	Employee Benefits		Generations HC Network, LLC		3,918	3,918	26
27	V								27
28	V	5	Utilities		Generations HC Network, LLC		1,579	1,579	28
29	V	6	Repairs & Maintenance		Generations HC Network, LLC		1,361	1,361	29
30	V	19	Professional Fees		Generations HC Network, LLC		385	385	30
31	V	21	Clerical & General		Generations HC Network, LLC		99	99	31
32	V	26	Insurance		Generations HC Network, LLC		193	193	32
33	V	30	Depreciation		Generations HC Network, LLC		4,029	4,029	33
34	V	32	Interest		Generations HC Network, LLC		2,923	2,923	34
35	V	33	Real Estate Taxes		Generations HC Network, LLC		7,005	7,005	35
36	V								36
37	V								37
38	V								38
39	Total			$ 40,410			$ 206,533	$ * 166,123	39

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

Facility Name & ID Number Greenwood Care # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	$ 11,835	MAC Rx, LLC		$ 10,729	$ (1,106)	15
16	V	21	Clerical & General Office Expenses	71	MAC Rx, LLC		64	(7)	16
17	V	22	Employee Benefits	1,713	MAC Rx, LLC		1,553	(160)	17
18	V	39	Ancillary		MAC Rx, LLC				18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 13,619			$ 12,347	$ * (1,273)	39

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

Facility Name & ID Number Greenwood Care # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$ 999	Big Ten Supply, LLC		$ 903	$ (96)	15
16	V	3	Housekeeping	28,610	Big Ten Supply, LLC		25,860	(2,750)	16
17	V	4	Laundry		Big Ten Supply, LLC				17
18	V	6	Repairs & Maintenance	2,223	Big Ten Supply, LLC		2,009	(214)	18
19	V	10	Nursing And Medical Records	34,791	Big Ten Supply, LLC		31,447	(3,344)	19
20	V	10A	Therapy		Big Ten Supply, LLC				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			$ 66,623			$ 60,220	$ * (6,403)	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Greenwood Care # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Greenwood Care # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Greenwood Care # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Bryan Barrish	Relative	Administrative		See Attached	1.98	4.96%	Alloc. Salary	$ 14,157	17-7	1
2	Kirsten Schloss	Relative	Maintenance		See Attached	2.27	5.66%	Alloc. Salary	8,829	6-7	2
3	Sarah Barrish	Relative	Administrative		See Attached	2.83	5.66%	Alloc. Salary	7,279	17-7	3
4	Louise Bergthold	Owner	Administrative	3.45%	See Attached	3.40	5.66%	Alloc. Salary	14,157	17-7	4
5	Michael Giannini	Relative	Administrative		See Attached	2.27	5.03%	Alloc. Salary	10,224	17-7	5
6	Nenita Guzman	Relative	Dietary		See Attached	2.27	5.66%	Alloc. Salary	5,879	1-7	6
7	Tom Winter	Relative	Administrative		See Attached	2.27	5.66%	Alloc. Salary	14,157	17-7	7
8	Thomas Bergthold	Relative	Clerical		See Attached	2.27	5.66%	Alloc. Salary	3,428	21-7	8
9	Clark Collins	Relative	Administrative		See Attached	0.57	1.43%	Alloc. Salary	757	Var.	9
10	See Supplemental Schedule								9,064		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	$ 87,932		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 # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

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]

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

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

	1 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 # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 [ ]

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

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

	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	2	Dietary Other and Rebates	Patient Days	832,144	19	$ (46,886)	$	47,124	$ (2,655)	1
2	6	Repairs & Maintanence	Patient Days	832,144	19	228,292	155,904	47,124	12,928	2
3	7	Emp. Ben. - General Svc.	Patient Days	832,144	19	28,781		47,124	1,630	3
4	9	Medical Director Consults	Patient Days	832,144	19			47,124		4
5	10	Nursing	Patient Days	832,144	19	1,095,433	1,094,370	47,124	62,034	5
6	15	Emp. Ben. - Health Care	Patient Days	832,144	19	204,429		47,124	11,577	6
7	17	Administrative	Patient Days	832,144	19	347,566	347,566	47,124	19,683	7
8	19	Professional Fees	Patient Days	832,144	19	138,762		47,124	7,858	8
9	20	Fee, Subscriptions	Patient Days	832,144	19	49,284		47,124	2,791	9
10	21	Clerical & General	Patient Days	832,144	19	4,236,976	3,850,828	47,124	239,938	10
11	24	Education & Seminar	Patient Days	832,144	19	6,287		47,124	356	11
12	25	Other Admin. Staff Transportatio	Patient Days	832,144	19	112,731		47,124	6,384	12
13	26	Insurance	Patient Days	832,144	19	32,419		47,124	1,836	13
14	27	Emp. Ben. - Gen. Admin.	Patient Days	832,144	19	371,977		47,124	21,065	14
15	32	Interest	Patient Days	832,144	19	(27,854)		47,124	(1,577)	15
16	35	Auto Rental	Patient Days	832,144	19	70,001		47,124	3,964	16
17	35	Equipment Rental	Patient Days	832,144	19	12,377		47,124	701	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 6,860,575	$ 5,448,668		$ 388,513	25

Facility Name & ID Number Greenwood Care # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

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

	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	832,144	19	$ 103,820	$ 103,820	47,124	$ 5,879	1
2	7	Emp. Ben. - Dietary	Patient Days	832,144	19	19,413		47,124	1,099	2
3	17	Admin./Legal Salaries	Patient Days	832,144	19	2,093,591	2,093,591	47,124	118,559	3
4	19	Fin. Consult./Regl. Dir.	Patient Days	832,144	19	208,920		47,124	11,831	4
5	27	Emp. Ben. - Administrative	Patient Days	832,144	19	485,424		47,124	27,489	5
6										6
7										7
8										8
9										9
10										10
11	6	Maintenance Salaries	Maintenance Income	702,930	17	726,469	726,469	19,530	20,184	11
12	7	Employee Benefits	Maintenance Income	702,930	17	141,032		19,530	3,918	12
13										13
14	5	Utilities	Allocated Sq. Ft.	12,879	19	27,900		729	1,579	14
15	6	Repairs & Maintenance	Allocated Sq. Ft.	12,879	19	24,049		729	1,361	15
16	19	Professional Fees	Allocated Sq. Ft.	12,879	19	6,801		729	385	16
17	21	Clerical & General	Allocated Sq. Ft.	12,879	19	1,754		729	99	17
18	26	Insurance	Allocated Sq. Ft.	12,879	19	3,403		729	193	18
19	30	Depreciation	Allocated Sq. Ft.	12,879	19	71,181		729	4,029	19
20	32	Interest	Allocated Sq. Ft.	12,879	19	51,631		729	2,923	20
21	33	Real Estate Taxes	Allocated Sq. Ft.	12,879	19	123,763		729	7,005	21
22										22
23										23
24										24
25	TOTALS					$ 4,089,151	$ 2,923,880		$ 206,533	25

Facility Name & ID Number Greenwood Care # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing And Medical Records	Direct Allocation			$	$		$ 10,729	1
2	21	Clerical & General Office Expens	Direct Allocation						64	2
3	22	Employee Benefits	Direct Allocation						1,553	3
4	39	Ancillary	Direct Allocation							4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 12,347	25

Facility Name & ID Number Greenwood Care # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			$	$		$ 903	1
2	3	Housekeeping	Direct Allocation						25,860	2
3	4	Laundry	Direct Allocation							3
4	6	Repairs & Maintenance	Direct Allocation						2,009	4
5	10	Nursing And Medical Records	Direct Allocation						31,447	5
6	10A	Therapy	Direct Allocation							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					$	$		$ 60,220	25

Facility Name & ID Number Greenwood Care # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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 # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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 # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	CIBC Bank	X		Mortgage			$	$ 10,017,325			$ 310,090	1
2	Unamortized Bond Premium						$	$ 553,037			$	2
3							$	$			$	3
4							$	$			$	4
5							$	$			$	5
	Working Capital											
6	Lake Forest Bank		X	Interest Only				-			15,119	6
7								-			-	7
8												8
9	TOTAL Facility Related						$	$ 10,570,362			$ 325,209	9
	B. Non-Facility Related*											
10	Interest Income		X								(8,449)	10
11	Interest Income		X								(30,700)	11
12	Interest Income - Bldg Co	X									(74)	12
13	See Supplemental Schedule										1,346	13
14	TOTAL Non-Facility Related						$	$			$ (37,877)	14
15	TOTALS (line 9+line14)						$	$ 10,570,362			$ 287,332	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 55,721 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 # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Item		Amount	Line
1. Real Estate Tax accrual used on 2019 report.	$	209,000	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.)	$	214,574	2
3. Under or (over) accrual (line 2 minus line 1).	$	5,574	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	217,950	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.)**	$	22,627	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND** $ ______ **For** ____ **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	246,151	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Year	Amount	Line
	2015	195,773	8
	2016	183,824	9
	2017	193,810	10
	2018	199,006	11
	2019	207,569	12

2020 Accrual = $207,569 x 1.05 = $217,950 (rounded)

Allocated from Generations HC: $7,005

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.**

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Greenwood Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054254

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	11-18-324-019-0000	Long Term Care Property	$ 207,569.44	$ 207,569.44
2.	10-31-401-046-0000	Allocated from Regency Property	$ 796,746.36	$ 547.95
3.	See Attached	Allocated from SIR Properties	$ 148,905.51	$ 6,600.92
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,153,221	$ 214,718

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 2019 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 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Greenwood Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054254

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1987	$ 152,555	1
2					2
3	TOTALS			$ 152,555	3

Facility Name & ID Number Greenwood Care # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 138,318	35	$	$ (138,318)	$ 1,845,500	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1984	2,672		20			2,672	9
10	Various			1987	24,869		20			24,869	10
11	Various			1988	27,733		20			27,733	11
12	Various			1989	7,668		20			7,668	12
13	Various			1990	9,800		20			9,800	13
14	Various			1992	25,025		20			25,025	14
15	Various			1993	63,911		20			63,911	15
16	Various			1994	20,319		20			20,319	16
17	Various			1995	73,839		20			73,839	17
18	Various			1996	109,220		20			109,220	18
19	Various			1997	73,171		20			73,171	19
20	Various			1998	58,371		20			58,371	20
21	Various			1999	179,834		20	45	45	179,616	21
22	Various			2000	171,876		20	2,503	2,503	171,874	22
23	Various			2001	43,730		20	2,186	2,186	42,625	23
24	Various			2002	87,606		20	3,432	3,432	81,903	24
25	Various			2003	59,109		20	1,707	1,707	54,350	25
26	Various			2004	77,107		20	3,144	3,144	66,544	26
27	Various			2005	58,861		20	2,618	2,618	46,993	27
28	Various			2006	271,462		20	13,574	13,574	197,458	28
29	Various			2007	153,877		20	7,339	7,339	107,428	29
30	Various			2008	29,039		20	1,453	1,453	18,034	30
31	Various			2009	36,735		20	1,837	1,837	21,288	31
32	Various			2010	11,568		20	578	578	11,086	32
33	Various			2011	11,264		20	563	563	7,879	33
34	Various			2012	56,176		20	2,809	2,809	26,793	34
35	Various			2013	6,322		20	316	316	2,371	35
36	Various			2015	2,983		20	149		758	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 # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	Various	2016	$ 11,842	$	20	$ 592	$ 592	$ 2,793	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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50									50
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59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		1,601,043			80,053	80,053	891,387	67
68	Related Party Allocations (Pages 12H & 12I)		126,084	2,256		3,561	1,305	80,837	68
69	Financial Statement Depreciation			35,822			(35,822)		69
70	TOTAL (lines 4 thru 69)		$ 5,338,616	$ 176,396		$ 128,459	$ (48,087)	$ 4,354,115	70

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

Facility Name & ID Number Greenwood Care # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 5,338,616	$ 176,396		$ 128,459	$ (47,938)	$ 4,354,115	1
2	Repaired Plumbing Pipes In Room 204/2Nd Flr Bath	2017	4,400		20	220	220	825	2
3	Remove And Replace Concrete	2018	6,750		20	338	338	760	3
4	Boiler System Repairs	2018	4,597		20	230	230	632	4
5	Fire Pump Repairs	2018	2,544		20	127	127	318	5
6	Fire Alarm System Upgrade	2018	4,249		20	212	212	495	6
7	Repaired Boiler System	2018	4,597		20	230	230	632	7
8	Refurbish Boiler	2020	60,016		20	3,001	3,001	3,001	8
9	Replaced Boiler Tank & Drain Line	2020	15,039		20	188	188	188	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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20									20
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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)		$ 5,440,808	$ 176,396		$ 133,005	$ (43,392)	$ 4,360,966	34

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

Facility Name & ID Number Greenwood Care # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 5,440,808	$ 176,396		$ 133,005	$ (43,392)	$ 4,360,966	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,440,808	$ 176,396		$ 133,005	$ (43,392)	$ 4,360,966	34

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

Facility Name & ID Number Greenwood Care # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 5,440,808	$ 176,396		$ 133,005	$ (43,392)	$ 4,360,966	1
2									2
3									3
4									4
5									5
6									6
7									7
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,440,808	$ 176,396		$ 133,005	$ (43,392)	$ 4,360,966	34

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

Facility Name & ID Number Greenwood Care # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 5,440,808	$ 176,396		$ 133,005	$ (43,392)	$ 4,360,966	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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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)		$ 5,440,808	$ 176,396		$ 133,005	$ (43,392)	$ 4,360,966	34

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

Facility Name & ID Number Greenwood Care # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	230706		20	11535	11,535	149,959	9
10	Various	2009	571486		20	28574	28,574	305,538	10
11	Various	2010	694673		20	34734	34,734	403,721	11
12	Grease Interceptor & Floor Drain	2011	7400		20	370	370	3,700	12
13	Coffee Shop Custom Cabinet	2011	3000		20	150	150	1,500	13
14	Duct Extensions - Community Bathrooms	2012	5321		20	266	266	2,394	14
15	Sprinkler System Repair	2012	3367		20	168	168	1,513	15
16	Boiler Repair	2012	3326		20	166	166	1,495	16
17	Kitchen-patch Walls & Paint	2012	3700		20	185	185	1,665	17
18	Elevator Generator	2013	5500		20	275	275	2,200	18
19	Nurse Call Annuciator	2013	8331		20	417	417	3,335	19
20	Camera Security System	2013	7230		20	362	362	2,895	20
21	Mounted Firedoor Holders	2015	6340		20	317	317	1,902	21
22	Replace Radiant Heat Lines	2015	6435		20	322	322	1,932	22
23	Removed & Installed Hot Water Storage Tank-Lower Level	2016	13950		20	698	698	3,489	23
24	Valve Replacement	2016	3319		20	166	166	830	24
25	HVAC Heat Pump Unit	2017	9126		20	456	456	1,825	25
26	15 Air Conditioners	2018	3293		20	165	165	494	26
27	Fire Pump Service	2019	5468		20	273	273	546	27
28	Repaired Elevator	2020	6140		20	307	307	307	28
29	Replace Window A/C unit	2020	2932		20	146.6	147	147	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,601,043	$		$ 80,053	$ 80,053	$ 891,387	34

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

Facility Name & ID Number Greenwood Care # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 1,601,043	$		$ 80,053	$ 80,053	$ 891,387	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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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,601,043	$		$ 80,053	$ 80,053	$ 891,387	34

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

Facility Name & ID Number Greenwood Care # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	28,302	755	39	726	(30)	8,013	3
4	Allocated from S.I.R. Properties/GHN	1993	25,622	813	35	732	(81)	19,400	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Generations Healthcare Network, LLC	1993	6,496	181	20		(181)	6,496	9
10	Allocated from Generations Healthcare Network, LLC	1994	20		20			20	10
11	Allocated from Generations Healthcare Network, LLC	1995	148		20			148	11
12	Allocated from Generations Healthcare Network, LLC	1997	9,982	224	20		(224)	9,982	12
13	Allocated from Generations Healthcare Network, LLC	1999	785		20	30	30	785	13
14	Allocated from Generations Healthcare Network, LLC	1999	8,112		20			8,112	14
15	Allocated from Generations Healthcare Network, LLC	2000	927		20	21	21	927	15
16	Allocated from Generations Healthcare Network, LLC	2007	2,977		20	149	149	1,964	16
17	Allocated from Generations Healthcare Network, LLC	2008	8,205		20	303	303	6,001	17
18	Allocated from Generations Healthcare Network, LLC	2009	20,389		20	1,019	1,019	11,463	18
19	Allocated from Generations Healthcare Network, LLC	2011	504	50	20	50		475	19
20	Allocated from Generations Healthcare Network, LLC	2012	1,614	81	20	81		599	20
21	Allocated from Generations Healthcare Network, LLC	2014	226	23	20	11	(11)	75	21
22	Allocated from Generations Healthcare Network, LLC	2016	294	15	20	15		65	22
23	Allocated from Generations Healthcare Network, LLC	2019	1,468	72	20	72		92	23
24	Allocated from Generations Healthcare Network, LLC	2020	1,196	25	20	25	0	25	24
25									25
26	Allocated from S.I.R. Properties/GHN	2012	1,569		20	78	78	550	26
27	Allocated from S.I.R. Properties/GHN	2010	1,546		20	77	77	722	27
28	Allocated from S.I.R. Properties/GHN	2009	1,538		20	77	77	831	28
29	Allocated from S.I.R. Properties/GHN	2007	152	9	20	8	(1)	99	29
30	Allocated from S.I.R. Properties/GHN	2002	102		20	5	5	89	30
31	Allocated from S.I.R. Properties/GHN	1999	3,247		20	81	81	3,247	31
32	Allocated from S.I.R. Properties/GHN	1994	244	6	20		(6)	244	32
33	Allocated from S.I.R. Properties/GHN	1993	416	2	20		(2)	416	33
34	TOTAL (lines 1 thru 33)		$ 126,084	$ 2,256		$ 3,561	$ 1,305	$ 80,837	34

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

Facility Name & ID Number Greenwood Care # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 126,084	$ 2,256		$ 3,561	$ 1,305	$ 80,837	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 126,084	$ 2,256		$ 3,561	$ 1,305	$ 80,837	34

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

Facility Name & ID Number Greenwood Care # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 245,905	$ 1,200	$ 24,303	$ 23,102	10	$ 232,874	71
72	Current Year Purchases	238	16	16	0	10	16	72
73	Fully Depreciated Assets	596,576				10	596,576	73
74								74
75	TOTALS	$ 842,719	$ 1,216	$ 24,319	$ 23,102		$ 829,466	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										77
78										78
79		See Attached		6,675	557	1,008	451		3,576	79
80	TOTALS			$ 20,812	$ 557	$ 1,008	$ 451		$ 17,713	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)	$ 6,456,894	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 178,170	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 158,331	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (19,838)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,208,145	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	Awning	$ 4,685	92
93			93
94			94
95		$ 4,685	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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	Storage Rental							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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 7,423 Description: See Attached
    (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 Generatio		$	$ 3,964	17
18					18
19					19
20					20
21	TOTAL		$	$ 3,964	21

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

** <u>This amount plus any amortization of lease expense must agree with page 4, line 34.</u>

Facility Name & ID Number Greenwood Care # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

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.

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.

Facility Name & ID Number Greenwood Care # 0054254 Report Period Beginning: 01/01/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (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	$ 116,924	$ 360,187	1
2	Cash-Patient Deposits	61,420	61,420	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	616,157	616,157	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,788	39,961	6
7	Other Prepaid Expenses	133,092	133,092	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		392,799	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 948,381	$ 1,603,616	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	1,152,619	2,516,218	15
16	Equipment, at Historical Cost	1,004,593	1,475,437	16
17	Accumulated Depreciation (book methods)	(1,565,065)	(4,880,868)	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):	1,619,543	1,669,796	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,211,690	$ 3,207,200	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,160,071	$ 4,810,816	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,114,078	$ 1,128,937	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	61,450	61,450	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	162,617	162,617	30
31	Accrued Taxes Payable (excluding real estate taxes)	141,294	141,294	31
32	Accrued Real Estate Taxes(Sch.IX-B)		217,950	32
33	Accrued Interest Payable		22,539	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		724,177	724,177	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,203,616	$ 2,458,964	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		10,017,325	40
41	Bonds Payable		553,037	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 10,570,362	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,203,616	$ 13,029,326	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 956,455	$ (8,218,510)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,160,071	$ 4,810,816	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,081,660	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,081,660	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(125,205)	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)**	$ (125,205)	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)**	$ 956,455	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	$ 5,996,367	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,996,367	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	7,500	24
25	Interest and Other Investment Income***	39,149	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 46,649	26
	E. Other Revenue (specify):*****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28		129,146	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 129,146	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,172,162	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,333,398	31
32	Health Care	2,132,901	32
33	General Administration	1,741,604	33
	B. Capital Expense		
34	Ownership	1,089,464	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)***	$ 6,297,367	40
41	**Income before Income Taxes (line 30 minus line 40)****	(125,205)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (125,205)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 442,889	44
45	Private Pay - Net Inpatient Revenue	74,620	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Managed Care / 5314976	5,478,858	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,996,367	49

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

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

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

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

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,986	2,090	$ 110,521	$ 52.88	1
2	Assistant Director of Nursing	1,954	2,090	55,321	26.47	2
3	Registered Nurses	1,716	1,862	55,428	29.77	3
4	Licensed Practical Nurses	12,529	13,365	371,229	27.78	4
5	CNAs & Orderlies	43,179	46,718	822,968	17.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,490	2,824	42,103	14.91	8
9	Activity Director					9
10	Activity Assistants	13,771	15,201	226,203	14.88	10
11	Social Service Workers	13,878	15,279	270,283	17.69	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,823	18,314	306,879	16.76	15
16	Dishwashers					16
17	Maintenance Workers	2,286	2,482	40,238	16.21	17
18	Housekeepers	19,040	20,522	340,663	16.60	18
19	Laundry					19
20	Administrator	1,438	1,516	83,727	55.23	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,263	11,357	176,104	15.51	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	1,791	2,132	29,157	13.68	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	143,144	155,752	$ 2,930,824 *	$ 18.82	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 31,238	01-03	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	64,380	10-03	38
39	Pharmacist Consultant	Monthly	9,939	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	Monthly	6,000	12-03	47
48					48
49	TOTAL (lines 35 - 48)		$ 111,557		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Stavropoulos Konstantinos	Administrator		$ 78,472
Neal Venis	Administrator		5,255
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 83,727

B. Administrative - Other

Description	Amount
SIR/Generations HN - Management Fees	$ 238,567
SIR/Generations HN - Director of Administrative Services	60,900
SIR/Generations HN - Ancillary Administrative Charges	52,198
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 351,665

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting Fee	$ 17,700
Plante & Moran PLLC	Accounting Fee	800
Pinnacle Quality Insights	Customer Satisfaction	2,238
PayChex	Payroll Processing	149
Paylocity	Payroll Processing	9,374
Thompson Coburn LLP	Tax Appeal	22,323
Joint Comm	Other Professional	5,200
CC Dropbox	Software Cost	474
GoDaddy	Software Cost	1,537
SIR/Generations HN	Computer Support Charges	27,840
See Attached	Legal	26,996
See Supplemental Schedule		244,442
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 359,073

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 23,534
Unemployment Compensation Insurance	56,277
FICA Taxes	224,208
Employee Health Insurance	56,160
Employee Meals	21,008
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits - Other	4,441
Employee Benefits - COVID-19	102
401K Matching Contr.	2,650
Union Pension Plan	30,386
Union Health & Welfare	99,106
TOTAL (agree to Schedule V, line 22, col.8)	$ 517,872

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	$ 5,700
Advertising: Employee Recruitment	10,708
Health Care Worker Background Check	
(Indicate # of checks performed 191.4)	1,914
Patient Background Checks	
Dues & Subscriptions	7,038
Licenses & Fees	12,695
See Supplemental Schedule	2,791
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 40,846

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	128
See Supplemental Schedule	356
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 484

**See instructions.

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. $ **708** 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. $ **21,008** 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 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.