

		FOR BHF USE					

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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.

<p>I. IDPH License ID Number: <u>0054254</u></p> <p>Facility Name: <u>Greenwood Care Ltd.</u></p> <p>Address: <u>1406 N. Chicago Ave.</u> <u>Evanston</u> <u>60201</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(847) 328-7508</u> Fax # <u>(847) 869-4878</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>1/1/1990</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/17</u> to <u>12/31/17</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) _____</td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>* Subject to the attached Accountants' Consulting Report</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td> </tr> </table> <p>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</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) _____		(Title) _____	Paid Preparer	(Signed) _____	(Date) _____	* Subject to the attached Accountants' Consulting Report	(Date) _____		(Print Name and Title) _____		(Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u>		(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																									
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Facility Name & ID Number Greenwood Care Ltd.

0054254 Report Period Beginning: 01/01/17 Ending: 12/31/17

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	5,309	1,110	38,966	45,385	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,309	1,110	38,966	45,385	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.75%

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

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

I. On what date did you start providing long term care at this location?
Date started 2/1/1987

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Greenwood Care Ltd. # 0054254 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	215,088	21,642	27,165	263,895		263,895	(11,236)	252,659		1
2	Food Purchase		242,452		242,452	(20,696)	221,757	(1,159)	220,598		2
3	Housekeeping	237,122	36,653		273,775		273,775	(2,832)	270,943		3
4	Laundry		9,961	13,027	22,988		22,988	(135)	22,853		4
5	Heat and Other Utilities			108,564	108,564		108,564	(11,937)	96,627		5
6	Maintenance	46,856	43,019	149,517	239,392		239,392	(10,143)	229,249		6
7	Other (specify):*							9,629	9,629		7
8	TOTAL General Services	499,066	353,727	298,273	1,151,066	(20,696)	1,130,371	(27,813)	1,102,557		8
	B. Health Care and Programs										
9	Medical Director			4,800	4,800		4,800	5,363	10,163		9
10	Nursing and Medical Records	1,159,819	29,139	56,301	1,245,259		1,245,259	(170)	1,245,089		10
10a	Therapy	42,845		24,192	67,037		67,037	(11,283)	55,754		10a
11	Activities	149,093	11,270	170	160,533		160,533		160,533		11
12	Social Services	312,525		3,600	316,125		316,125		316,125		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							8,372	8,372		15
16	TOTAL Health Care and Programs	1,664,282	40,409	89,063	1,793,754		1,793,754	2,282	1,796,036		16
	C. General Administration										
17	Administrative	75,769		336,426	412,195		412,195	(221,301)	190,894		17
18	Directors Fees										18
19	Professional Services			255,335	255,335	(18,274)	237,061	(156,272)	80,790		19
20	Dues, Fees, Subscriptions & Promotions			62,544	62,544		62,544	(23,754)	38,790		20
21	Clerical & General Office Expenses	149,052	20,523	53,206	222,781		222,781	87,954	310,735		21
22	Employee Benefits & Payroll Taxes			417,331	417,331	20,696	438,027	(132)	437,895		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,240	3,240		3,240	150	3,390		24
25	Other Admin. Staff Transportation			2,864	2,864		2,864	9,166	12,030		25
26	Insurance-Prop.Liab.Malpractice			108,780	108,780		108,780	8,964	117,744		26
27	Other (specify):*							34,839	34,839		27
28	TOTAL General Administration	224,821	20,523	1,239,726	1,485,070	2,422	1,487,492	(260,385)	1,227,107		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,388,169	414,659	1,627,062	4,429,890	(18,274)	4,411,616	(285,917)	4,125,700		29

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

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

Facility Name & ID Number

Greenwood Care Ltd.

#0054254

Report Period Beginning:

01/01/17

Ending:

12/31/17

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			41,539	41,539		41,539	137,816	179,355			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,282	21,282		21,282	357,954	379,236			32
33	Real Estate Taxes					18,274	18,274	178,727	197,001			33
34	Rent-Facility & Grounds			996,000	996,000		996,000	(996,000)				34
35	Rent-Equipment & Vehicles			6,107	6,107		6,107	4,133	10,240			35
36	Other (specify):*							59,825	59,825			36
37	TOTAL Ownership			1,064,928	1,064,928	18,274	1,083,202	(257,545)	825,657			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)	2,388,169	414,659	2,691,990	5,494,818		5,494,818	(543,462)	4,951,356			45

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

Facility Name & ID Number Greenwood Care Ltd.

0054254

Report Period Beginning:

01/01/17

Ending:

12/31/17

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(13,621)	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	(34,370)	30		9
10	Interest and Other Investment Income	(23,864)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(59)	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	(12,545)	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	(17,380)	21		24
25	Fund Raising, Advertising and Promotional	(3,598)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(35,710)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (141,147)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(402,314)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (402,314)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (543,461)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

Greenwood Care Ltd.

ID# 0054254

Report Period Beginning: 01/01/17

Ending: 12/31/17

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Bank Fees	\$ (7,319)	21	1
2	Theft and Damage Loss	(846)	21	2
3	Vending Income	(1,100)	02	3
4	Jury Duty Income	(69)	10	4
5	Alliance for Living	(7,860)	20	5
6	Non-Allowable Legal	(2,754)	19	6
7	Capitalized R&M	(4,400)	06	7
8	Building Co - Amortization	(2,101)	36	8
9	Building Co - Filing Fees	(350)	20	9
10	Building Co - Office Expense	(12)	21	10
11	Building Co - Professional Fees	(8,900)	19	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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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	(35,710)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Greenwood Care Ltd.# 0054254

Report Period Beginning:

01/01/17

Ending:

12/31/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				(11,236)								(11,236)	1
2	Food Purchase	(1,159)											(1,159)	2
3	Housekeeping						(2,832)						(2,832)	3
4	Laundry						(135)						(135)	4
5	Heat and Other Utilities	(13,621)			1,684								(11,937)	5
6	Maintenance	(4,400)	1,859	(9,691)	2,089								(10,143)	6
7	Other (specify):*			1,087	8,542								9,629	7
8	TOTAL General Services	(19,180)	1,859	(8,604)	1,079		(2,967)						(27,813)	8
	B. Health Care and Programs													
9	Medical Director			5,363									5,363	9
10	Nursing and Medical Records	(69)		(4,088)	7,026	(1,052)	(1,987)						(170)	10
10a	Therapy				(11,283)								(11,283)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			4,806	3,566								8,372	15
16	TOTAL Health Care and Programs	(69)		6,081	(692)	(1,052)	(1,987)						2,282	16
	C. General Administration													
17	Administrative			(314,248)	92,947								(221,301)	17
18	Directors Fees													18
19	Professional Services	(11,654)	8,900	(166,672)	13,154								(156,272)	19
20	Fees, Subscriptions & Promotions	(24,353)	350	249									(23,754)	20
21	Clerical & General Office Expenses	(25,557)	12	113,400	135	(8)	(28)						87,954	21
22	Employee Benefits & Payroll Taxes					(132)							(132)	22
23	Inservice Training & Education													23
24	Travel and Seminar			150									150	24
25	Other Admin. Staff Transportation			9,166									9,166	25
26	Insurance-Prop.Liab.Malpractice		7,259	1,530	175								8,964	26
27	Other (specify):*			11,945	22,894								34,839	27
28	TOTAL General Administration	(61,564)	16,521	(344,480)	129,305	(140)	(28)						(260,385)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(80,812)	18,380	(347,003)	129,693	(1,192)	(4,982)						(285,917)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Greenwood Care Ltd. # 0054254 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(34,370)	166,243		5,943								137,816	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(23,864)	380,582	(3,718)	4,954								357,954	32
33	Real Estate Taxes		171,324		7,403								178,727	33
34	Rent-Facility & Grounds		(996,000)										(996,000)	34
35	Rent-Equipment & Vehicles			4,133									4,133	35
36	Other (specify):*	(2,101)	61,926										59,825	36
37	TOTAL Ownership	(60,335)	(215,925)	415	18,300								(257,545)	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)	(141,147)	(197,545)	(346,588)	147,993	(1,192)	(4,982)						(543,462)	45

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. 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)	
1	V	34 Rent	\$ 996,000	Greenwood Care LLC	100.00%	\$	(996,000)	1
2	V	32 Interest	156	Greenwood Care LLC	100.00%	380,738	380,582	2
3	V	36 Amortization		Greenwood Care LLC	100.00%	2,101	2,101	3
4	V	06 Repairs and Maintenance		Greenwood Care LLC	100.00%	1,859	1,859	4
5	V	20 Filing Fees		Greenwood Care LLC	100.00%	350	350	5
6	V	36 Mortgage Insurance		Greenwood Care LLC	100.00%	59,825	59,825	6
7	V	21 Office Expense		Greenwood Care LLC	100.00%	12	12	7
8	V	26 Property Insurance		Greenwood Care LLC	100.00%	7,259	7,259	8
9	V	33 Real Estate Taxes	21,676	Greenwood Care LLC	100.00%	193,000	171,324	9
10	V	30 Depreciation		Greenwood Care LLC	100.00%	166,243	166,243	10
11	V	19 Professional Fees		Greenwood Care LLC	100.00%	8,900	8,900	11
12	V							12
13	V							13
14	Total		\$ 1,017,832			\$ 820,287	\$ * (197,545)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 REPAIRS AND MAINT.	\$ 21,312	GENERATIONS HC NETWORK, LLC	100.00%	\$ 11,621	\$ (9,691)
16	V	7 EMP. BEN.-GEN. SERV.		GENERATIONS HC NETWORK, LLC	100.00%	1,087	1,087
17	V	9 MEDICAL DIRECTOR CONSULTS		GENERATIONS HC NETWORK, LLC	100.00%	5,363	5,363
18	V	10 NURSING	42,636	GENERATIONS HC NETWORK, LLC	100.00%	38,548	(4,088)
19	V	15 EMP. BEN.-H.C.		GENERATIONS HC NETWORK, LLC	100.00%	4,806	4,806
20	V	17 ADMINISTRATIVE	336,426	GENERATIONS HC NETWORK, LLC	100.00%	22,178	(314,248)
21	V	19 PROFESSIONAL FEES	168,072	GENERATIONS HC NETWORK, LLC	100.00%	1,400	(166,672)
22	V	20 FEES,SUBSCRIPTIONS		GENERATIONS HC NETWORK, LLC	100.00%	249	249
23	V	21 CLERICAL & GENERAL	7,140	GENERATIONS HC NETWORK, LLC	100.00%	120,540	113,400
24	V	24 EDUCATION & SEMINAR		GENERATIONS HC NETWORK, LLC	100.00%	150	150
25	V	25 OTHER ADMIN. STAFF TRANS.		GENERATIONS HC NETWORK, LLC	100.00%	9,166	9,166
26	V	26 INSURANCE		GENERATIONS HC NETWORK, LLC	100.00%	1,530	1,530
27	V	27 EMP. BEN.-GEN. ADMIN.		GENERATIONS HC NETWORK, LLC	100.00%	11,945	11,945
28	V	32 INTEREST		GENERATIONS HC NETWORK, LLC	100.00%	(3,718)	(3,718)
29	V	35 AUTO RENTAL		GENERATIONS HC NETWORK, LLC	100.00%	3,389	3,389
30	V	35 EQUIPMENT RENTAL		GENERATIONS HC NETWORK, LLC	100.00%	744	744
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 575,586			\$ 228,998	\$ * (346,588)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1	DIETARY SALARIES	\$ 17,748	GENERATIONS HC NETWORK, LLC	100.00%	\$ 6,512	\$ (11,236)	15
16	V	7	EMP. BEN.-DIETARY		GENERATIONS HC NETWORK, LLC	100.00%	1,128	1,128	16
17	V	10	NURSING SALARIES		GENERATIONS HC NETWORK, LLC	100.00%	7,026	7,026	17
18	V	15	EMP. BEN.-NURSING		GENERATIONS HC NETWORK, LLC	100.00%	1,213	1,213	18
19	V	17	ADMIN./LEGAL SALARIES		GENERATIONS HC NETWORK, LLC	100.00%	92,947	92,947	19
20	V	19	FIN. CONSULT./REGL. DIR.		GENERATIONS HC NETWORK, LLC	100.00%	13,080	13,080	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		GENERATIONS HC NETWORK, LLC	100.00%	22,894	22,894	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	24,792	GENERATIONS HC NETWORK, LLC	100.00%	13,509	(11,283)	24
25	V	15	EMPLOYEE BENEFITS		GENERATIONS HC NETWORK, LLC	100.00%	2,353	2,353	25
26	V								26
27	V	6	MAINTENANCE SALARIES	39,784	GENERATIONS HC NETWORK, LLC	100.00%	40,818	1,034	27
28	V	7	EMPLOYEE BENEFITS		GENERATIONS HC NETWORK, LLC	100.00%	7,414	7,414	28
29	V								29
30	V	5	UTILITIES		GENERATIONS HC NETWORK, LLC	100.00%	1,684	1,684	30
31	V	6	REPAIRS AND MAINT.		GENERATIONS HC NETWORK, LLC	100.00%	1,055	1,055	31
32	V	19	PROFESSIONAL FEES		GENERATIONS HC NETWORK, LLC	100.00%	74	74	32
33	V	21	CLERICAL & GENERAL		GENERATIONS HC NETWORK, LLC	100.00%	135	135	33
34	V	26	INSURANCE		GENERATIONS HC NETWORK, LLC	100.00%	175	175	34
35	V	30	DEPRECIATION		GENERATIONS HC NETWORK, LLC	100.00%	5,943	5,943	35
36	V	32	INTEREST		GENERATIONS HC NETWORK, LLC	100.00%	4,954	4,954	36
37	V	33	REAL ESTATE TAXES		GENERATIONS HC NETWORK, LLC	100.00%	7,403	7,403	37
38	V								38
39	Total		\$ 82,324				\$ 230,317	\$ * 147,993	39

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

Facility Name & ID Number Greenwood Care Ltd.

0054254

Report Period Beginning: 01/01/17

Ending: 12/31/17

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	06 Maintenance	\$	MAC Rx, LLC	100.00%	\$		15
16	V	10 Nursing and Medical Records	12,735	MAC Rx, LLC	100.00%	11,683	(1,052)	16
17	V	10A Therapy		MAC Rx, LLC	100.00%			17
18	V	19 Professional Services		MAC Rx, LLC	100.00%			18
19	V	21 Clerical & General Office Expenses	98	MAC Rx, LLC	100.00%	89	(8)	19
20	V	22 Employee Benefits	1,595	MAC Rx, LLC	100.00%	1,463	(132)	20
21	V	39 Ancillary		MAC Rx, LLC	100.00%			21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 14,428			\$ 13,236	\$ * (1,192)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Big Ten Supply, LLC	100.00%	\$	\$
16	V	3 Housekeeping	32,674	Big Ten Supply, LLC	100.00%	29,842	(2,832)
17	V	4 Laundry	1,559	Big Ten Supply, LLC	100.00%	1,423	(135)
18	V	6 Repairs & Maintenance		Big Ten Supply, LLC	100.00%		
19	V	10 Nursing And Medical Records	22,922	Big Ten Supply, LLC	100.00%	20,935	(1,987)
20	V	10A Therapy		Big Ten Supply, LLC	100.00%		
21	V	21 Clerical & General	324	Big Ten Supply, LLC	100.00%	296	(28)
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 57,479			\$ 52,496	\$ * (4,982)

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

Facility Name & ID Number Greenwood Care Ltd.

0054254

Report Period Beginning: 01/01/17

Ending: 12/31/17

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 Ltd.

0054254

Report Period Beginning: 01/01/17

Ending: 12/31/17

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.

VII. RELATED PARTIES (continued)

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

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

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

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 Ltd.

0054254

Report Period Beginning:

01/01/17

Ending:

12/31/17

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1	Bryan Barrish	Relative	Administrative		See Attached	2.29	5.73%	Alloc. Salary	\$ 13,080	17-7	1	
2	Kirsten Schloss	Relative	Maintenance		See Attached	3.27	6.54%	Alloc. Salary	6,222	6-7	2	
3	Sarah Barrish	Relative	Administrative		See Attached	3.27	6.54%	Alloc. Salary	8,161	17-7	3	
4	Louise Bergthold	Owner	Administrative	3.45%	See Attached	3.92	6.53%	Alloc. Salary	13,080	17-7	4	
5	Michael Giannini	Relative	Administrative		See Attached	2.29	5.73%	Alloc. Salary	11,118	17-7	5	
6	Nenita Guzman	Relative	Dietary		See Attached	3.27	6.54%	Alloc. Salary	6,512	1-7	6	
7	Tom Winter	Owner	Administrative	4.14%	See Attached	3.92	6.53%	Alloc. Salary	13,080	17-7	7	
8	Thomas Bergthold	Relative	Clerical		See Attached	2.62	6.55%	Alloc. Salary	2,726	21-7	8	
9	Clark Collins	Relative	Administrative		See Attached	1.00	2.50%	Alloc. Salary	1,245	Var	9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 75,224		13	

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

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

Facility Name & ID Number Greenwood Care Ltd.

0054254

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Greenwood Care Ltd.

0054254

Report Period Beginning:

01/01/17

Ending: 12/31/17

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 GENERATIONS HC NETWORK, LLC
 Street Address 6840 N. LINCOLN
 City / State / Zip Code LINCOLNWOOD, IL. 60712
 Phone Number (847) 675 -7979
 Fax Number (847) 675 -0555

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	REPAIRS AND MAINT.	PATIENT DAYS	693,985	14	\$ 177,702	\$ 95,737	45,385	\$ 11,621	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	693,985	14	16,617		45,385	1,087	2
3	9	MEDICAL DIRECTOR CONSUM	PATIENT DAYS	693,985	14	82,000		45,385	5,363	3
4	10	NURSING	PATIENT DAYS	693,985	14	589,441	589,441	45,385	38,548	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	693,985	14	73,484		45,385	4,806	5
6	17	ADMINISTRATIVE	PATIENT DAYS	693,985	14	339,126	339,126	45,385	22,178	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	693,985	14	21,409		45,385	1,400	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	693,985	14	3,801		45,385	249	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	693,985	14	1,843,191	1,656,700	45,385	120,540	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	693,985	14	2,295		45,385	150	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	693,985	14	140,164		45,385	9,166	11
12	26	INSURANCE	PATIENT DAYS	693,985	14	23,394		45,385	1,530	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	693,985	14	182,645		45,385	11,945	13
14	32	INTEREST	PATIENT DAYS	693,985	14	(56,845)		45,385	(3,718)	14
15	35	AUTO RENTAL	PATIENT DAYS	693,985	14	51,827		45,385	3,389	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	693,985	14	11,377		45,385	744	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,501,628	\$ 2,681,003		\$ 228,998	25

Facility Name & ID Number Greenwood Care Ltd.

0054254

Report Period Beginning:

01/01/17

Ending: 12/31/17

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 GENERATIONS HC NETWORK, LLC
 Street Address 6840 N. LINCOLN
 City / State / Zip Code LINCOLNWOOD, IL. 60712
 Phone Number (847) 675 -7979
 Fax Number (847) 675 -0555

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY SALARIES	PATIENT DAYS	693,985	14	\$ 99,579	\$ 99,579	45,385	\$ 6,512	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	693,985	14	17,250		45,385	1,128	2
3	10	NURSING SALARIES	PATIENT DAYS	693,985	14	107,435	107,435	45,385	7,026	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	693,985	14	18,544		45,385	1,213	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	693,985	14	1,421,258	1,421,258	45,385	92,947	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	693,985	14	200,000		45,385	13,080	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	693,985	14	350,079		45,385	22,894	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	329,142	13	179,343	179,343	24,792	13,509	10
11	15	EMPLOYEE BENEFITS	SPECIAL REHAB INC.	329,142	13	31,236		24,792	2,353	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	366,497	14	376,026	376,026	39,784	40,818	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	366,497	14	68,296		39,784	7,414	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,877	14	25,758		842	1,684	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,877	14	16,130		842	1,055	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,877	14	1,139		842	74	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,877	14	2,063		842	135	19
20	26	INSURANCE	ALLOCATED SQ FT	12,877	14	2,682		842	175	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,877	14	90,892		842	5,943	21
22	32	INTEREST	ALLOCATED SQ FT	12,877	14	75,767		842	4,954	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,877	14	113,223		842	7,403	23
24										24
25	TOTALS					\$ 3,196,700	\$ 2,183,641		\$ 230,317	25

Facility Name & ID Number Greenwood Care Ltd.

0054254

Report Period Beginning:

01/01/17

Ending: 12/31/17

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 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	06	Maintenance	Direct Allocation		\$	\$		\$	1
2	10	Nursing And Medical Records	Direct Allocation					11,683	2
3	10A	Therapy	Direct Allocation						3
4	19	Professional Services	Direct Allocation						4
5	21	Clerical & General Office Expense	Direct Allocation					89	5
6	22	Employee Benefits	Direct Allocation					1,463	6
7	39	Ancillary	Direct Allocation						7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 13,236	25

Facility Name & ID Number Greenwood Care Ltd.

0054254

Report Period Beginning:

01/01/17

Ending: 12/31/17

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 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation		\$	\$		\$	1
2	3	Housekeeping	Direct Allocation					29,842	2
3	4	Laundry	Direct Allocation					1,423	3
4	6	Repairs & Maintenance	Direct Allocation						4
5	10	Nursing And Medical Records	Direct Allocation					20,935	5
6	10A	Therapy	Direct Allocation						6
7	21	Clerical & General	Direct Allocation					296	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 52,496	25

Facility Name & ID Number Greenwood Care Ltd.

0054254

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____

Fax Number (_____

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

Facility Name & ID Number Greenwood Care Ltd.

0054254

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Greenwood Care Ltd.

0054254

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Greenwood Care Ltd.

0054254 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Greenwood Care Ltd.

0054254

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number

Greenwood Care Ltd.

0054254

Report Period Beginning:

01/01/17

Ending:

12/31/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	The Private Bank		X	Mortgage			\$	10,769,527		\$	380,738	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	Lake Forest Bank		X	Line of Credit				300,000			21,282	6								
7												7								
8												8								
9	TOTAL Facility Related						\$	11,069,527		\$	402,020	9								
B. Non-Facility Related*																				
10	Interest Income		X								(23,864)	10								
11	Interest Income - Bldg Co		X								(156)	11								
12	Allocated from Generations HC		X								1,236	12								
13												13								
14	TOTAL Non-Facility Related						\$			\$	(22,784)	14								
15	TOTALS (line 9+line14)						\$	11,069,527		\$	379,236	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 59,825 Line # 36

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

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

Facility Name & ID Number **Greenwood Care Ltd.**

0054254

Report Period Beginning:

01/01/17

Ending:

12/31/17

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.

1. Real Estate Tax accrual used on 2016 report.		\$	205,500	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.)		\$	191,227	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(14,273)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	193,000	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.)		\$	18,274	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 \$ <u>72,075</u> For <u>2013-15</u> 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.		\$	197,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	188,087	8
	2013	193,972	9
	2014	193,911	10
	2015	195,773	11
	2016	183,824	12

2017 Accrual: \$183,824 x 1.05 = \$193,000 (Rounded)

Allocated from Generations HC Network LLC: \$7,403

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2016	\$	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

Facility Name & ID Number Greenwood Care Ltd.

0054254 Report Period Beginning:

01/01/17 Ending:

12/31/17

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

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.

Table with 4 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost. Row 1: Facility, 1987, \$152,555. Row 2: (blank). Row 3: TOTALS, \$152,555.

Facility Name & ID Number Greenwood Care Ltd.

0054254

Report Period Beginning:

01/01/17

Ending:

12/31/17

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	145	1987	1969	\$ 1,845,500	\$	35	\$	\$	\$ 1,845,500	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Various		1984	2,672		20	76	76	2,412	9
10	Various		1987	24,869		20	694	694	22,593	10
11	Various		1988	27,733		20	321	321	21,282	11
12	Various		1989	7,668		20	87	87	6,027	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	1,806	1,806	73,167	19
20	Various		1998	58,371		20	2,919	2,919	56,849	20
21	Various		1999	179,834		20	9,323	9,323	172,448	21
22	Various		2000	171,876		20	8,594	8,594	152,184	22
23	Various		2001	43,730		20	2,186	2,186	36,835	23
24	Various		2002	87,606		20	3,432	3,432	71,605	24
25	Various		2003	59,109		20	1,707	1,707	49,229	25
26	Various		2004	77,107		20	3,144	3,144	57,115	26
27	Various		2005	58,861		20	2,618	2,618	39,148	27
28	Various		2006	271,462		20	13,574	13,574	156,739	28
29	Various		2007	153,877		20	7,515	7,515	85,411	29
30	Various		2008	29,039		20	1,453	1,453	13,678	30
31	Various		2009	36,735		20	1,837	1,837	15,779	31
32	Various		2010	11,568		20	1,157	1,157	8,194	32
33	Various		2011	11,264		20	826	826	5,663	33
34	Various		2012	56,176		20	3,138	3,138	17,708	34
35	Various		2013	6,322		20	316	316	1,422	35
36										36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Greenwood Care Ltd.

0054254

Report Period Beginning:

01/01/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		1,583,210	137,485		75,021	(62,464)	652,406	67
68		124,967	3,555		4,156	601	77,814	68
69			41,539			(41,539)		69
70		\$ 5,304,841	\$ 182,579		\$ 145,900	\$ (36,679)	\$ 3,943,322	70

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

Facility Name & ID Number Greenwood Care Ltd.

0054254

Report Period Beginning:

01/01/17

Ending:

12/31/17

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		\$ 5,304,841	\$ 182,579		\$ 145,900	\$ (36,679)	\$ 3,943,322	1
2	Walk In Cooler Repair	2015	2,983		20	149	149	311	2
3	Fire Rated Speaker Cover	2016	2,566		20	128	128	257	3
4	Repaired Steam Piping Valves	2016	3,725		20	186	186	357	4
5	Repaired A/C In Lunchroom	2016	2,520		20	126	126	189	5
6	Installed Lead Free Multi Valve	2016	3,031		20	152	152	215	6
7	Repaired Plumbing Pipes In Room 204/2Nd Floor Bath	2017	4,400		20	220	220	220	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,324,066	\$ 182,579		\$ 146,861	\$ (35,718)	\$ 3,944,871	34

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

Facility Name & ID Number Greenwood Care Ltd.

0054254

Report Period Beginning:

01/01/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 5,324,066	\$ 182,579		\$ 146,861	\$ (35,718)	\$ 3,944,871	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 5,324,066	\$ 182,579		\$ 146,861	\$ (35,718)	\$ 3,944,871	34

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

Facility Name & ID Number Greenwood Care Ltd.

0054254

Report Period Beginning:

01/01/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 5,324,066	\$ 182,579		\$ 146,861	\$ (35,718)	\$ 3,944,871	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 5,324,066	\$ 182,579		\$ 146,861	\$ (35,718)	\$ 3,944,871	34

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

Facility Name & ID Number Greenwood Care Ltd.

0054254

Report Period Beginning:

01/01/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 5,324,066	\$ 182,579		\$ 146,861	\$ (35,718)	\$ 3,944,871	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 5,324,066	\$ 182,579		\$ 146,861	\$ (35,718)	\$ 3,944,871	34

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

Facility Name & ID Number Greenwood Care Ltd.

0054254

Report Period Beginning:

01/01/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Various	2008	230,706		20	11,535	11,535	115,350	9
10	Various	2009	571,486		20	24,434	24,434	219,815	10
11	Various	2010	694,673		20	34,734	34,734	299,520	11
12	Grease Interceptor & Floor Drain	2011	7,400		20	370	370	2,590	12
13	Coffee Shop Custom Cabinet	2011	3,000		20	150	150	1,050	13
14	Duct extensions- community bathrooms	2012	5,321		20	266	266	1,596	14
15	Sprinkler System Repair	2012	3,367		20	168	168	1,008	15
16	Boiler Repair	2012	3,326		20	166	166	996	16
17	Kitchen-patch walls and paint	2012	3,700		20	185	185	1,110	17
18	Elevator Generator	2013	5,500		20	275	275	1,375	18
19	Nurse Call Annunciator	2013	8,331		20	417	417	2,085	19
20	Camera Security System	2013	7,230		20	362	362	1,810	20
21	Mounted Firedoor Holders	2015	6,340		20	317	317	951	21
22	Replace Radiant Heat Lines	2015	6,435		20	322	322	966	22
23	Removed and Installed Hot Water Storage Tank -Lower Level	2016	13,950		20	698	698	1,396	23
24	Valve Replacement	2016	3,319		20	166	166	332	24
25	HVAC Heat Pump Unit	2017	9,126		20	456	456	456	25
26									26
27									27
28	Depreciation			137,485			(137,485)		28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,583,210	\$ 137,485		\$ 75,021	\$ (62,464)	\$ 652,406	34

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

Facility Name & ID Number Greenwood Care Ltd.

0054254

Report Period Beginning:

01/01/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 1,583,210	\$ 137,485		\$ 75,021	\$	\$ 652,406	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 1,583,210	\$ 137,485		\$ 75,021	\$	\$ 652,406	34

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

Facility Name & ID Number Greenwood Care Ltd.

0054254

Report Period Beginning:

01/01/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocation from Generations Healthcare Network	2009	16,347	434	39	419	(15)	3,371	3
4	Allocation from SIR Properties/Generations Healthcare Network	1993	29,599	940	35	846	(94)	20,719	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocation from Generations Healthcare Network	1993	7,504	209	20		(209)	7,504	9
10	Allocation from Generations Healthcare Network	1994	23		20			23	10
11	Allocation from Generations Healthcare Network	1995	172		20			172	11
12	Allocation from Generations Healthcare Network	1997	11,531	516	20	193	(323)	11,531	12
13	Allocation from Generations Healthcare Network	1999	907		20	45	45	827	13
14	Allocation from Generations Healthcare Network	1999	8,112		20			8,112	14
15	Allocation from Generations Healthcare Network	2000	1,070		20	53	53	939	15
16	Allocation from Generations Healthcare Network	2007	3,439		20	172	172	1,753	16
17	Allocation from Generations Healthcare Network	2008	9,479	948	20	597	(351)	5,882	17
18	Allocation from Generations Healthcare Network	2009	23,553	215	20	1,178	963	9,709	18
19	Allocation from Generations Healthcare Network	2011	583	58	20	58		374	19
20	Allocation from Generations Healthcare Network	2012	1,865	93	20	93		518	20
21	Allocation from Generations Healthcare Network	2014	262	26	20	13	(13)	47	21
22	Allocation from Generations Healthcare Network	2016	340	17	20	17		24	22
23	Allocation from SIR Properties/Generations Healthcare Network	2012	1,813	79	20	91	12	454	23
24	Allocation from SIR Properties/Generations Healthcare Network	2010	1,786		20	89	89	655	24
25	Allocation from SIR Properties/Generations Healthcare Network	2009	1,777		20	89	89	782	25
26	Allocation from SIR Properties/Generations Healthcare Network	2007	175	10	20	9	(1)	96	26
27	Allocation from SIR Properties/Generations Healthcare Network	2002	117		20	6	6	91	27
28	Allocation from SIR Properties/Generations Healthcare Network	1999	3,751		20	188	188	3,469	28
29	Allocation from SIR Properties/Generations Healthcare Network	1994	282	7	20		(7)	282	29
30	Allocation from SIR Properties/Generations Healthcare Network	1993	480	3	20		(3)	480	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 124,967	\$ 3,555		\$ 4,156	\$ 601	\$ 77,814	34

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

Facility Name & ID Number Greenwood Care Ltd.

0054254

Report Period Beginning:

01/01/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$ 124,967	\$ 3,555		\$ 4,156	\$ 601	\$ 77,814
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 124,967	\$ 3,555		\$ 4,156	\$ 601	\$ 77,814

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

Facility Name & ID Number Greenwood Care Ltd.

0054254

Report Period Beginning:

01/01/17

Ending:

12/31/17

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	\$ 793,085	\$ 30,945	\$ 30,853	\$ (93)	10	\$ 702,924	71
72	Current Year Purchases	4,656		466	466	10	466	72
73	Fully Depreciated Assets	46,988		1,025	1,025	10	46,988	73
74								74
75	TOTALS	\$ 844,729	\$ 30,945	\$ 32,343	\$ 1,398		\$ 750,377	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		PASSENGER VAN	2007	\$ 14,137	\$	\$	\$	5	\$ 14,137	76
77		Allocated from Generations HC N	2017	2,299	201	151	(50)	5	1,920	77
78										78
79										79
80	TOTALS			\$ 16,436	\$ 201	\$ 151	\$ (50)		\$ 16,057	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)	\$ 6,337,786	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 213,725	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 179,355	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (34,370)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,711,305	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Greenwood Care Ltd.

0054254

Report Period Beginning: 01/01/17

Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	<u> </u> /2018	\$ <u> </u>
13.	<u> </u> /2019	\$ <u> </u>
14.	<u> </u> /2020	\$ <u> </u>

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 6,851

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Allocated from Generations HC Network</u>		\$	\$ <u>3,389</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 3,389	21

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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.)

	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 prescripts							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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/17**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 85,443	\$ 198,800	1
2	Cash-Patient Deposits	40,390	40,390	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	613,363	613,363	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,692	48,083	6
7	Other Prepaid Expenses	5,527	5,527	7
8	Accounts Receivable (owners or related parties)	350,000	350,000	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,122,415	\$ 1,256,163	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		152,555	13
14	Buildings, at Historical Cost		2,274,062	14
15	Leasehold Improvements, at Historical Cost	1,070,814	2,422,805	15
16	Equipment, at Historical Cost	1,004,593	1,472,742	16
17	Accumulated Depreciation (book methods)	(1,450,899)	(4,311,296)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>		441,084	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 624,508	\$ 2,451,952	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,746,923	\$ 3,708,115	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 187,908	\$ 187,909	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	40,390	40,390	28
29	Short-Term Notes Payable	300,000	544,086	29
30	Accrued Salaries Payable	183,758	183,758	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,328	9,328	31
32	Accrued Real Estate Taxes(Sch.IX-B)		193,000	32
33	Accrued Interest Payable		31,411	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	169,516	169,516	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 890,900	\$ 1,359,398	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		10,525,441	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>		658,912	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 11,184,353	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 890,900	\$ 12,543,751	46
47	TOTAL EQUITY(page 18, line 24)	\$ 856,023	\$ (8,835,636)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,746,923	\$ 3,708,115	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,088,948	1
2	Restatements (describe):		2
3	Rounding	3	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,088,951	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(232,928)	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)	\$ (232,928)	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)	\$ 856,023	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Greenwood Care Ltd.

0054254

Report Period Beginning: 01/01/17

Ending:

12/31/17

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

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

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,164,627	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,164,627	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	23,864	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 23,864	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	73,399	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 73,399	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,261,890	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,151,066	31
32	Health Care	1,793,754	32
33	General Administration	1,485,070	33
B. Capital Expense			
34	Ownership	1,064,928	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,494,818	40
41	Income before Income Taxes (line 30 minus line 40)**	(232,928)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (232,928)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 607,718	44
45	Private Pay - Net Inpatient Revenue	142,125	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Managed Care	4,414,784	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,164,627	49

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

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

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

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

Facility Name & ID Number Greenwood Care Ltd.

0054254

Report Period Beginning:

01/01/17

Ending:

12/31/17

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	1,873	2,086	\$ 94,831	\$ 45.46	1
2	Assistant Director of Nursing	1,451	1,543	40,984	26.56	2
3	Registered Nurses	2,723	2,994	77,493	25.88	3
4	Licensed Practical Nurses	11,796	12,318	304,364	24.71	4
5	CNAs & Orderlies	45,411	48,671	603,623	12.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,781	3,098	42,845	13.83	8
9	Activity Director					9
10	Activity Assistants	13,455	14,252	149,093	10.46	10
11	Social Service Workers	17,152	18,526	296,974	16.03	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,491	17,758	215,088	12.11	15
16	Dishwashers					16
17	Maintenance Workers	3,236	3,565	46,856	13.14	17
18	Housekeepers	18,281	19,874	237,122	11.93	18
19	Laundry					19
20	Administrator	1,577	1,733	75,769	43.72	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,536	11,542	149,052	12.91	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	2,328	2,576	38,524	14.95	31
32	Other Health Care(specify)					32
33	Other(specify)	3,452	3,452	15,551	4.51	33
34	TOTAL (lines 1 - 33)	152,543	163,988	\$ 2,388,169 *	\$ 14.56	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	\$ 27,165	01-03	35
36	Medical Director	Monthly	4,800	09-03	36
37	Medical Records Consultant	Monthly	4,800	10-03	37
38	Nurse Consultant	Monthly	42,636	10-03	38
39	Pharmacist Consultant	Monthly	8,610	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	Per Visit	170	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychiatric Consultant	Monthly	3,600	12-03	47
48	Specialized Rehab	Monthly	24,192	10A-03	48
49	TOTAL (lines 35 - 48)		\$ 115,973		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	5	\$ 255	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	5	\$ 255		53

Facility Name & ID Number **Greenwood Care Ltd.**

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Report Period Beginning: **01/01/17**

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Laurie Daugherty	Administrator	0.00%	\$ 75,769	Workers' Compensation Insurance	\$ 35,279	IDPH License Fee	\$ 3,102		
				Unemployment Compensation Insurance	24,974	Advertising: Employee Recruitment	7,374		
				FICA Taxes	178,887	Health Care Worker Background Check	3,435		
				Employee Health Insurance	147,005	(Indicate # of checks performed <u>344</u>)			
				Employee Meals	20,696	Patient Background Checks	680		
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	14,124		
				Union Pension Plan	21,503	License and Permits	9,826		
				401K Match	3,700	Allocated from Generations HC Network	249		
				Other Employee Benefits	5,851				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 75,769	TOTAL (agree to Schedule V, line 22, col.8)		\$ 437,894	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 38,790
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
SIR/Generations HN - Consulting Fees			\$ 258,114				Out-of-State Travel	\$	
SIR/Generations HN - Director of Administrative Services			42,636				In-State Travel		
SIR/Generations HN - Ancillary Administrative Charges			35,676				Seminar Expense	3,240	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 336,426				Allocated from Generations HC Network	150	
C. Professional Services				TOTAL			Entertainment Expense		
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)		
Marcum LLP	Accounting		\$ 13,525						
RSM US LLP	Accounting		1,751						
SIR/Generations HN	Bookkeeping		65,688						
SIR/Generations HN	Dir. Of Regulatory Services		21,312						
SIR/Generations HN	Dir. Of Financial Services		42,000						
SIR/Generations HN	Director of Admissions		30,192						
SIR/Generations HN	Director of IT		8,880						
SIR/Generations HN	Computer Support		19,572						
Pinnacle Quality Insights	Customer Satisfaction		2,897						
Paychex	Payroll Processing		15,573						
Thompson Coburn LLP	RE Appeal		18,274						
See Supplemental Schedule			15,671						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 255,335				TOTAL		\$ 3,390

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Greenwood Care Ltd.# 0054254

Report Period Beginning:

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Ending:

12/31/17**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. \$ 383 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 20,696 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees