FOR BHF USE

LL1

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

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.

I. IDPH License ID Number: 0049973

Facility Name: Generations at Neighbors

Address: 811 West 2nd Street (Number) Byron (City) 61010 (Zip Code)

County: Ogle

Telephone Number: (815) 234 - 2511 **Fax #** (815) 234 - 3114

HFS ID Number:

Date of Initial License for Current Owners: 07/10/08

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Edward N. Slack, CPA **Telephone Number:** (847) 628 - 8796
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Edward N. Slack, CPA, Partner, Health and Human Services
(Firm Name & Address) Plante & Moran, PLLC, 2155 Point Boulevard, Suite 200 Elgin, Illinois 60123
(Telephone) (847) 628 - 8796 Fax # (248) 327 - 8417

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	101	Skilled (SNF)	101	36,966	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	101	TOTALS	101	36,966	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED	16,745	2,757	4,597	24,099	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,745	2,757	4,597	24,099	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.19%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 06/12/08

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/12/08 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 101 and days of care provided 1,726

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	229,837	26,825	21,428	278,090		278,090	(9,004)	269,086			1
2	Food Purchase		149,582		149,582		149,582	(534)	149,048			2
3	Housekeeping	124,124	20,715		144,839		144,839	(1,389)	143,450			3
4	Laundry	83,614	35,392		119,006		119,006	(10)	118,996			4
5	Heat and Other Utilities			93,593	93,593		93,593	949	94,542			5
6	Maintenance	31,379	23,349	150,883	205,611		205,611	20,944	226,555			6
7	Other (specify):* See Supplemental							11,214	11,214			7
8	**TOTAL General Services**	468,954	255,863	265,904	990,721		990,721	22,170	1,012,891			8
	B. Health Care and Programs											
9	Medical Director			17,400	17,400		17,400	502	17,902			9
10	Nursing and Medical Records	990,677	99,283	455,509	1,545,469		1,545,469	(15,228)	1,530,241			10
10a	Therapy	83,711		10,432	94,143		94,143	(4,691)	89,452			10a
11	Activities	90,280	9,091	1,747	101,118		101,118		101,118			11
12	Social Services	72,686		1,747	74,433		74,433		74,433			12
13	CNA Training											13
14	Program Transportation			2,578	2,578		2,578		2,578			14
15	Other (specify):* See Supplemental							3,698	3,698			15
16	**TOTAL Health Care and Programs**	1,237,354	108,374	489,413	1,835,141		1,835,141	(15,719)	1,819,422			16
	C. General Administration											
17	Administrative	91,475			91,475		91,475	52,788	144,263			17
18	Directors Fees											18
19	Professional Services			256,498	256,498		256,498	(187,190)	69,308			19
20	Dues, Fees, Subscriptions & Promotions			82,400	82,400		82,400	(43,093)	39,307			20
21	Clerical & General Office Expenses	134,696	26,372	113,664	274,732		274,732	(24,151)	250,581			21
22	Employee Benefits & Payroll Taxes			329,802	329,802		329,802	(152)	329,650			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,879	3,879		3,879	235	4,114			24
25	Other Admin. Staff Transportation			11,059	11,059		11,059	3,465	14,524			25
26	Insurance-Prop.Liab.Malpractice			73,830	73,830		73,830	22,804	96,634			26
27	Other (specify):* See Supplemental							15,982	15,982			27
28	**TOTAL General Administration**	226,171	26,372	871,132	1,123,675		1,123,675	(159,311)	964,364			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,932,479	390,609	1,626,449	3,949,537		3,949,537	(152,860)	3,796,677			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Generations at Neighbors
Medicaid Cost Report
01/01/16 - 12/31/16

Page 3 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 7 - Other General Services				
Alloc. - SIR Mgmt / Generations HCN				-
Employee Benefits			11,214	11,214
				-
				-
				-
				-
				-
Sub-Total	-	-	11,214	11,214
Line 15 - Other Health Care Services				
Alloc. - SIR Mgmt / Generations HCN				-
Employee Benefits			3,698	3,698
				-
				-
				-
				-
				-
Sub-Total	-	-	3,698	3,698
Line 27 - Other General Administration				
Alloc. - SIR Mgmt / Generations HCN				-
Employee Benefits			15,982	15,982
				-
				-
				-
				-
				-
Sub-Total	-	-	15,982	15,982

Facility Name & ID Number Generations at Neighbors #0049973 Report Period Beginning: 01/01/16 Ending: 12/31/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			39,269	39,269		39,269	201,887	241,156			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			75,737	75,737		75,737	318,203	393,940			32
33	Real Estate Taxes			66,300	66,300		66,300	8,498	74,798			33
34	Rent-Facility & Grounds			207,000	207,000		207,000	(207,000)				34
35	Rent-Equipment & Vehicles			2,618	2,618		2,618	2,560	5,178			35
36	Other (specify):* See Supplemental											36
37	**TOTAL Ownership**			390,924	390,924		390,924	324,148	715,072			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		57,818	244,191	302,009		302,009	(4,136)	297,873			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			193,482	193,482		193,482		193,482			42
43	Other (specify):* See Supplemental	47,308		20,604	67,912		67,912	(67,912)				43
44	**TOTAL Special Cost Centers**	47,308	57,818	458,277	563,403		563,403	(72,048)	491,355			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,979,787	448,427	2,475,650	4,903,864		4,903,864	99,240	5,003,104			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Generations at Neighbors
Medicaid Cost Report
01/01/16 - 12/31/16

Page 4 Supplemental Schedule

Line 36 - Other Capital Costs

Description	Salaries	Supplies	Other	Total
				-
				-
				-
				-
				-
				-
				-
Sub-Total	-	-	-	-

Line 43 - Other Special Cost Centers

Marketing	47,308		20,604	67,912
				-
				-
				-
				-
				-
				-
Sub-Total	47,308	-	20,604	67,912

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/16 Ending: 12/31/16

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(19,851)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(534)	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	(1,239)	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	(70,679)	21		24
25	Fund Raising, Advertising and Promotional	(42,674)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(12)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Supplemental Schedule	(139,908)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (274,897)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	374,137		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 374,137		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 99,240		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Generations at Neighbors

ID# 0049973

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Legal Fees - Collections	$ (4,424)	19	1
2	Legal Fees - Non Allowable	(4,222)	19	2
3	Bank Fees	(11,440)	21	3
4	Jury Duty Income	(25)	10	4
5	Capitalized Assets < $2,500 Expensed	6,789	06	5
6	Marketing Salary	(67,912)	43	6
7				7
8				8
9				9
10				10
11				11
12	Neighbors Property, LLC - Non Allowable			12
13	Professional Fees	(15,000)	19	13
14	Dues and Subscriptions	(1,875)	20	14
15	Office and Clerical	(40)	21	15
16	Amortization	(41,760)	31	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(139,908)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	(8,844)	(160)	0	0	0	0	0	0	(9,004)	1
2	Food Purchase	(534)	0	0	0	0	0	0	0	0	0	0	(534)	2
3	Housekeeping	0	0	0	0	(1,389)	0	0	0	0	0	0	(1,389)	3
4	Laundry	0	0	0	0	(10)	0	0	0	0	0	0	(10)	4
5	Heat and Other Utilities	0	0	0	949	0	0	0	0	0	0	0	949	5
6	Maintenance	6,789	11,035	2,641	792	(313)	0	0	0	0	0	0	20,944	6
7	Other (specify):*	0	0	0	11,214	0	0	0	0	0	0	0	11,214	7
8	**TOTAL General Services**	6,255	11,035	2,641	4,111	(1,872)	0	0	0	0	0	0	22,170	8
	B. Health Care and Programs													
9	Medical Director	0	0	502	0	0	0	0	0	0	0	0	502	9
10	Nursing and Medical Records	(25)	0	16,537	(27,963)	(3,515)	(262)	0	0	0	0	0	(15,228)	10
10a	Therapy	0	0	0	(4,691)	0	0	0	0	0	0	0	(4,691)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	2,194	1,504	0	0	0	0	0	0	0	3,698	15
16	**TOTAL Health Care and Programs**	(25)	0	19,233	(31,150)	(3,515)	(262)	0	0	0	0	0	(15,719)	16
	C. General Administration													
17	Administrative	0	0	11,372	41,416	0	0	0	0	0	0	0	52,788	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(23,646)	15,000	(185,472)	6,928	0	0	0	0	0	0	0	(187,190)	19
20	Fees, Subscriptions & Promotions	(45,788)	1,875	820	0	0	0	0	0	0	0	0	(43,093)	20
21	Clerical & General Office Expenses	(82,171)	40	57,922	61	0	(3)	0	0	0	0	0	(24,151)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	(152)	0	0	0	0	0	(152)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	235	0	0	0	0	0	0	0	0	235	24
25	Other Admin. Staff Transportation	0	0	3,465	0	0	0	0	0	0	0	0	3,465	25
26	Insurance-Prop.Liab.Malpractice	0	21,878	842	84	0	0	0	0	0	0	0	22,804	26
27	Other (specify):*	0	0	5,842	10,140	0	0	0	0	0	0	0	15,982	27
28	**TOTAL General Administration**	(151,604)	38,793	(104,974)	58,629	0	(155)	0	0	0	0	0	(159,311)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(145,374)	49,828	(83,100)	31,590	(5,387)	(417)	0	0	0	0	0	(152,860)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Generations at Neighbors # 0049973 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	198,901	0	2,986	0	0	0	0	0	0	0	201,887	30
31	Amortization of Pre-Op. & Org.	(41,760)	41,760	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(19,851)	337,134	(1,952)	2,872	0	0	0	0	0	0	0	318,203	32
33	Real Estate Taxes	0	4,936	0	3,562	0	0	0	0	0	0	0	8,498	33
34	Rent-Facility & Grounds	0	(207,000)	0	0	0	0	0	0	0	0	0	(207,000)	34
35	Rent-Equipment & Vehicles	0	0	2,560	0	0	0	0	0	0	0	0	2,560	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(61,611)	375,731	608	9,420	0	0	0	0	0	0	0	324,148	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	(4,136)	0	0	0	0	0	(4,136)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(67,912)	0	0	0	0	0	0	0	0	0	0	(67,912)	43
44	TOTAL Special Cost Centers	(67,912)	0	0	0	0	(4,136)	0	0	0	0	0	(72,048)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(274,897)	425,559	(82,492)	41,010	(5,387)	(4,553)	0	0	0	0	0	99,240	45

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 207,000	Neighbors Property, LLC	100.00%	$	$ (207,000)	1
2	V	33	Real Estate Taxes	66,300	Neighbors Property, LLC	100.00%		(66,300)	2
3	V	6	Maintenance		Neighbors Property, LLC	100.00%	11,035	11,035	3
4	V	19	Professional Fees		Neighbors Property, LLC	100.00%	15,000	15,000	4
5	V	20	Dues and Subscriptions		Neighbors Property, LLC	100.00%	1,875	1,875	5
6	V	21	Office and Clerical		Neighbors Property, LLC	100.00%	40	40	6
7	V	26	Insurance		Neighbors Property, LLC	100.00%	21,878	21,878	7
8	V	30	Depreciation		Neighbors Property, LLC	100.00%	198,901	198,901	8
9	V	31	Amortization		Neighbors Property, LLC	100.00%	41,760	41,760	9
10	V	32	Interest		Neighbors Property, LLC	100.00%	337,134	337,134	10
11	V	33	Real Estate Taxes		Neighbors Property, LLC	100.00%	71,236	71,236	11
12	V								12
13	V								13
14	Total			$ 273,300			$ 698,859	$ * 425,559	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2	Atied Associates, LLC	36.28%	Albany Care	Cook, IL	Neighbors Property	Lincolnwood, IL	Bldg. Company	2
3	Barrish Group Limited Property	12.75%	Generations at Applewood, LLC	Matteson, IL	Generations HC			3
4	Bryan Barrish Trust D/T/D 09/01/04	12.75%	Bryn Mawr Care, Inc.	Chicago, IL	Transitions	Lincolnwood, IL	Mgmt. Company	4
5	Michael Giannini Trust	10.79%	Generations at Columbus Park, LLC	Chicago, IL	SIR Management	Lincolnwood, IL	Mgmt. Company	5
6	Ralph Gesualdo	12.75%	Decatur Manor Healthcare, LLC	Decatur, IL	SIR Properties	Lincolnwood, IL	Bldg. Company	6
7	Ralph Gesualdo Children Trust	12.75%	Generations at Elmwood Park, LLC	Elmwood Park, IL	Max RX, LLC	Des Plaines, IL	Pharmacy	7
8	Thomas Winter	1.94%	Greenwood Care, Inc.	Evanston, IL	LTC Lab, LLC	Lincolnwood, IL	Ancillary Supplies	8
9			Maplewood Care, Inc.	Elgin, IL				9
10			Generations at Neighbors, LLC	Byron, IL				10
11			Generations at Oakton Pavilion, LLC	Des Plaines, IL				11
12			Generations at Oakton Arms, LLC	Des Plaines, IL				12
13			Generations at Regency, LLC	Niles, IL				13
14			Generations at Rock Island, LLC	Rock Island, IL				14
15			Auburn Village	Auburn, IL				15
16			Wilson Care, Inc.	Chicago, IL				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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Maintenance	$	SIR Mgmt. Inc. & Generations HC Network, LLC	100.00%	$ 2,641	$ 2,641	15
16	V	9	Medical Director		SIR Mgmt. Inc. & Generations HC Network, LLC	100.00%	502	502	16
17	V	10	Nursing		SIR Mgmt. Inc. & Generations HC Network, LLC	100.00%	16,537	16,537	17
18	V	15	Emp. Ben. - Health Care		SIR Mgmt. Inc. & Generations HC Network, LLC	100.00%	2,194	2,194	18
19	V	17	Administrative		SIR Mgmt. Inc. & Generations HC Network, LLC	100.00%	11,372	11,372	19
20	V	19	Professional Fees	187,464	SIR Mgmt. Inc. & Generations HC Network, LLC	100.00%	1,992	(185,472)	20
21	V	20	Dues, Fees, and Subscriptions		SIR Mgmt. Inc. & Generations HC Network, LLC	100.00%	820	820	21
22	V	21	Office and Clerical		SIR Mgmt. Inc. & Generations HC Network, LLC	100.00%	57,922	57,922	22
23	V	24	Education and Seminar		SIR Mgmt. Inc. & Generations HC Network, LLC	100.00%	235	235	23
24	V	25	Other Admin. Staff Transportation		SIR Mgmt. Inc. & Generations HC Network, LLC	100.00%	3,465	3,465	24
25	V	26	Insurance		SIR Mgmt. Inc. & Generations HC Network, LLC	100.00%	842	842	25
26	V	27	Emp. Ben. - Gen. Administration		SIR Mgmt. Inc. & Generations HC Network, LLC	100.00%	5,842	5,842	26
27	V	32	Interest		SIR Mgmt. Inc. & Generations HC Network, LLC	100.00%	(1,952)	(1,952)	27
28	V	35	Rental - Auto		SIR Mgmt. Inc. & Generations HC Network, LLC	100.00%	2,164	2,164	28
29	V	35	Rental - Equipment		SIR Mgmt. Inc. & Generations HC Network, LLC	100.00%	396	396	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			$ 187,464			$ 104,972	$ * (82,492)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$ 12,120	SIR Mgmt. Inc. & Generations HC Network, LLC	100.00%	$ 3,276	$ (8,844)	15
16	V	7	Emp. Ben. - Gen. Services		SIR Mgmt. Inc. & Generations HC Network, LLC	100.00%	573	573	16
17	V	10	Nursing	31,512	SIR Mgmt. Inc. & Generations HC Network, LLC	100.00%	3,549	(27,963)	17
18	V	15	Emp. Ben. - Health Care		SIR Mgmt. Inc. & Generations HC Network, LLC	100.00%	619	619	18
19	V	17	Administration		SIR Mgmt. Inc. & Generations HC Network, LLC	100.00%	41,416	41,416	19
20	V	19	Professional Fees		SIR Mgmt. Inc. & Generations HC Network, LLC	100.00%	6,692	6,692	20
21	V	27	Emp. Ben. - Gen. Administration		SIR Mgmt. Inc. & Generations HC Network, LLC	100.00%	10,140	10,140	21
22	V								22
23	V	10A	Rehab	9,696	SIR Mgmt. Inc. & Generations HC Network, LLC	100.00%	5,005	(4,691)	23
24	V	15	Emp. Ben. - Health Care		SIR Mgmt. Inc. & Generations HC Network, LLC	100.00%	885	885	24
25	V								25
26	V	6	Maintenance	14,544	SIR Mgmt. Inc. & Generations HC Network, LLC	100.00%	59,906	45,362	26
27	V	7	Emp. Ben. - Gen. Services		SIR Mgmt. Inc. & Generations HC Network, LLC	100.00%	10,641	10,641	27
28	V								28
29	V	5	Utilities		SIR Mgmt. Inc. & Generations HC Network, LLC	100.00%	949	949	29
30	V	6	Maintenance	44,942	SIR Mgmt. Inc. & Generations HC Network, LLC	100.00%	372	(44,570)	30
31	V	19	Professional Fees		SIR Mgmt. Inc. & Generations HC Network, LLC	100.00%	236	236	31
32	V	21	Office and Cliercal		SIR Mgmt. Inc. & Generations HC Network, LLC	100.00%	61	61	32
33	V	26	Insurance		SIR Mgmt. Inc. & Generations HC Network, LLC	100.00%	84	84	33
34	V	30	Depreciation		SIR Mgmt. Inc. & Generations HC Network, LLC	100.00%	2,986	2,986	34
35	V	32	Interst		SIR Mgmt. Inc. & Generations HC Network, LLC	100.00%	2,872	2,872	35
36	V	33	Real Estate Taxes		SIR Mgmt. Inc. & Generations HC Network, LLC	100.00%	3,562	3,562	36
37	V								37
38	V								38
39	Total			$ 112,814			$ 153,824	$ * 41,010	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$ 2,183	Big Ten Supply, LLC	100.00%	$ 2,023	$ (160)	15
16	V	3	Housekeeping	18,950	Big Ten Supply, LLC	100.00%	17,561	(1,389)	16
17	V	4	Laundry	133	Big Ten Supply, LLC	100.00%	123	(10)	17
18	V	6	Maintenance	4,266	Big Ten Supply, LLC	100.00%	3,953	(313)	18
19	V	10	Nursing	47,981	Big Ten Supply, LLC	100.00%	44,466	(3,515)	19
20	V	10A	Rehab		Big Ten Supply, LLC	100.00%			20
21	V	22	Employee Benefits		Big Ten Supply, LLC	100.00%			21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 73,513			$ 68,126	$ * (5,387)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing	$ 3,637	Max RC, LLC	100.00%	$ 3,375	$ (262)	15
16	V	21	Office and Clerical	33	Max RC, LLC	100.00%	30	(3)	16
17	V	22	Employee Benefits	2,118	Max RC, LLC	100.00%	1,966	(152)	17
18	V	39	Ancillary	57,425	Max RC, LLC	100.00%	53,289	(4,136)	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			$ 63,213			$ 58,660	$ * (4,553)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bryan Barrish	Relative	Administrative	0.000%	See Attachment	1.34	3.35%	Salary	$ 6,692	17 - 7	1
2	Sarah Barrish	Relative	Administrative	0.000%	See Attachment	1.67	3.34%	Salary	4,126	17 - 7	2
3	Kristen Schloss	Relative	Maintenance	0.000%	See Attachment	1.67	3.34%	Salary	3,196	6 - 7	3
4	Michael Giannini	Relative	Administrative	0.000%	See Attachment	1.17	2.93%	Salary	5,688	17 - 7	4
5	Nenita Guzman	Relative	Dietary	0.000%	See Attachment	1.67	3.34%	Salary	3,276	1 - 7	5
6	Thomas Winter	Owner	Administrative	1.940%	See Attachment	2.01	3.35%	Salary	6,692	17 - 7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 29,670		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Neighbors Property, LLC
Street Address: 6840 N. Lincoln
City / State / Zip Code: Lincolnwood, Illinois 60712
Phone Number: (847) 675 - 7979
Fax Number: (847) 675 - 0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: SIR Mgmt & Generations HC Network, LLC
Street Address: 6840 N. Lincoln
City / State / Zip Code: Lincolnwood, Illinois 60712
Phone Number: (847) 675 - 7979
Fax Number: (847) 675 - 0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Patient Days	712,171	14	$ 78,945	$	23,829	$ 2,641	1
2	9	Medical Director	Patient Days	712,171	14	15,000		23,829	502	2
3	10	Nursing	Patient Days	712,171	14	494,227	494,227	23,829	16,537	3
4	15	Emp. Ben. - Health Care	Patient Days	712,171	14	65,558		23,829	2,194	4
5	17	Administrative	Patient Days	712,171	14	339,874	339,874	23,829	11,372	5
6	19	Professional Fees	Patient Days	712,171	14	59,533		23,829	1,992	6
7	20	Dues, Fees, and Subscriptions	Patient Days	712,171	14	24,522		23,829	820	7
8	21	Office and Clerical	Patient Days	712,171	14	1,731,089	1,318,665	23,829	57,922	8
9	24	Education and Seminar	Patient Days	712,171	14	7,033		23,829	235	9
10	25	Other Admin. Staff Transp.	Patient Days	712,171	14	103,561		23,829	3,465	10
11	26	Insurance	Patient Days	712,171	14	25,150		23,829	842	11
12	27	Emp. Ben. - Gen. Admin.	Patient Days	712,171	14	174,591		23,829	5,842	12
13	32	Interest	Patient Days	712,171	14	(58,326)		23,829	(1,952)	13
14	35	Rental - Auto	Patient Days	712,171	14	64,663		23,829	2,164	14
15	35	Rental - Equipment	Patient Days	712,171	14	11,842		23,829	396	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,137,262	$ 2,152,766		$ 104,972	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: SIR Mgmt & Generations HC Network, LLC
Street Address: 6840 N. Lincoln
City / State / Zip Code: Lincolnwood, Illinois 60712
Phone Number: (847) 675 - 7979
Fax Number: (847) 675 - 0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	712,171	14	$ 97,898	$ 97,898	23,829	$ 3,276	1
2	7	Emp. Ben. - Gen. Services	Patient Days	712,171	14	17,139		23,829	573	2
3	10	Nursing	Patient Days	712,171	14	106,059	106,059	23,829	3,549	3
4	15	Emp. Ben. - Health Care	Patient Days	712,171	14	18,488		23,829	619	4
5	17	Administration	Patient Days	712,171	14	1,237,797	1,115,138	23,829	41,416	5
6	19	Professional Fees	Patient Days	712,171	14	200,000		23,829	6,692	6
7	27	Emp. Ben. - Gen. Admin.	Patient Days	712,171	14	303,056		23,829	10,140	7
8										8
9	10A	Rehab	Special Rehab	322,920	13	166,688	166,688	9,696	5,005	9
10	15	Emp. Ben. - Health Care	Special Rehab	322,920	13	29,469		9,696	885	10
11										11
12	6	Maintenance	Maintenance	335,151	14	446,742	446,742	44,942	59,906	12
13	7	Emp. Ben. - Gen. Services	Maintenance	335,151	14	79,358		44,942	10,641	13
14										14
15	5	Utilities	Alloc. Square Feet	12,878	14	28,358		431	949	15
16	6	Maintenance	Alloc. Square Feet	12,878	14	11,129		431	372	16
17	19	Professional Fees	Alloc. Square Feet	12,878	14	7,038		431	236	17
18	21	Office and Cliercal	Alloc. Square Feet	12,878	14	1,812		431	61	18
19	26	Insurance	Alloc. Square Feet	12,878	14	2,507		431	84	19
20	30	Depreciation	Alloc. Square Feet	12,878	14	89,214		431	2,986	20
21	32	Interst	Alloc. Square Feet	12,878	14	85,804		431	2,872	21
22	33	Real Estate Taxes	Alloc. Square Feet	12,878	14	106,445		431	3,562	22
23										23
24										24
25	TOTALS					$ 3,035,001	$ 1,932,525		$ 153,824	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation			$	$		$ 2,023	1
2	3	Housekeeping	Direct Allocation						17,561	2
3	4	Laundry	Direct Allocation						123	3
4	6	Maintenance	Direct Allocation						3,953	4
5	10	Nursing	Direct Allocation						44,466	5
6	10A	Rehab	Direct Allocation							6
7	22	Employee Benefits	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					$	$		$ 68,126	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing	Direct Allocation			$	$		$ 3,375	1
2	21	Office and Clerical	Direct Allocation						30	2
3	22	Employee Benefits	Direct Allocation						1,966	3
4	39	Ancillary	Direct Allocation						53,289	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					$	$		$ 58,660	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Private Bank		X	Mortgage		12/01/16	$ 11,635,822	$ 11,635,822		5.5000	$ 319,079	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Private Bank		X	Line of Credit				873,000			26,294	6
7	Private Bank		X	Van				1,430			193	7
8	Shareholder Loans	X		Line of Credit				2,405,000			67,305	8
9	TOTAL Facility Related						$ 11,635,822	$ 14,915,252			$ 412,871	9
	B. Non-Facility Related*											
10	Alloc. SIR / Generations	X									920	10
11												11
12												12
13	Interest Income										(19,851)	13
14	TOTAL Non-Facility Related						$	$			$ (18,931)	14
15	TOTALS (line 9+line14)						$ 11,635,822	$ 14,915,252			$ 393,940	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 0 Line # N/A

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Generations at Neighbors **#** 0049973 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	60,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	67,798	2
3. Under or (over) accrual (line 2 minus line 1).	$	7,798	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	67,000	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.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	74,798	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	56,599	8
	2012	58,482	9
	2013	59,072	10
	2014	59,839	11
	2015	64,236	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

Real Estate Tax Accrual = $64,236 * 1.04 = $67,000

Alloc. SIR Management = $3,562

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.** **This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Generations at Neighbors COUNTY Ogle

FACILITY IDPH LICENSE NUMBER 0049973

CONTACT PERSON REGARDING THIS REPORT Edward N. Slack, CPA

TELEPHONE (847) 628 - 8796 FAX #: (248) 327 - 8417

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-31-201-004	Long Term Care Facility	$ 64,236.42	$ 64,236.42
2.	Alloc. - SIR Management	Long Term Care Facility	$ 96,859.26	$ 3,241.68
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 161,095.68	$ 67,478.10

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 34,195 B. General Construction Type: Exterior Brick Frame Concrete Number of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Physical Therapy Room for non-residents. Applicable costs have been adjusted out on Page 5A.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2008	$ 170,000	1
2					2
3	TOTALS			$ 170,000	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	101		2008	1971	$ 2,175,000	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2008	30,221						9
10	Various			2009	31,966						10
11	Various			2010	29,530						11
12	Various			2011	286,651						12
13	Various			2012	83,020						13
14	Anti Freeze Loop Sprinkler			2013	3,397						14
15	HVAC Roof-Top Units			2013	9,471						15
16	Door Holders and Alarm Devices			2013	2,653						16
17	Security System			2013	5,790						17
18	Seal Coating & Asphalt Repairs			2013	3,778						18
19	Plumbing Backflow Device			2013	2,716						19
20	10 Air Conditioners			2013	5,525						20
21	Drainage Tile Installation & Gutter Repair			2013	2,627						21
22	Backflow Device			2014	3,198						22
23	Parking Lot Paving			2014	14,321						23
24	Doors			2014	2,549						24
25	Boiler Repair - New Valve, Pump, and Bearing Assembly			2015	3,401						25
26	Northern Mechanical - Hot Water Heater			2016	9,506						26
27											27
28	Neighbors Property, LLC										28
29	Drywall / Hallways 100 & 400			2014	44,751						29
30	Drywall / Hallways 200 & 300			2015	43,700						30
31	Construction - Bed Addition (30) Building Demolition and Rebuild			2016	10,179,462						31
32											32
33											33
34											34
35											35
36											36

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

See Page 12A, Line 70 for total

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 12,973,233	$		$	$	$	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 12,973,233	$		$	$	$	1
2									2
3	SIR Mgmt / Generations HC Network, LLC								3
4									4
5	Various	1993	3,841						5
6	Various	1994	12						6
7	Various	1995	88						7
8	Various	1997	5,902						8
9	Various	1999	16,734						9
10	Various	1999	464						10
11	Various	1999							11
12	Various	2000	548						12
13	Various	2007	1,760						13
14	Various	2008	4,852						14
15	Various	2009	12,055						15
16	Various	2011	298						16
17	Various	2012	954						17
18	Various	2014	134						18
19	Various	2016	174						19
20									20
21	SIR Mgmt / Generations HC Network, LLC								21
22									22
23	Various	1993	15,150						23
24	Various	1993	246						24
25	Various	1994	144						25
26	Various	1997	57						26
27	Various	1998	917						27
28	Various	1999	1,920						28
29	Various	2002	60						29
30	Various	2007	265						30
31	Various	2009	910						31
32	Various	2010	914						32
33	Various	2012	928						33
34	TOTAL (lines 1 thru 33)		$ 13,042,560	$		$	$	$	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 13,042,560	$		$	$	$	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	FS Depreciation - Generations at Neighbors, LLC			39,269		39,269		233,878	30
31	FS Depreciation - Neighbors Properties, LLC			198,901		198,901		1,249,912	31
32	FS Depreciation - SIR Mgmt / Generations HC Network, LLC			2,986		2,986		70,977	32
33									33
34	TOTAL (lines 1 thru 33)		$ 13,042,560	$ 241,156		$ 241,156	$	$ 1,554,767	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 568,510	$	$	$		$	71
72	Current Year Purchases	785,442						72
73	Fully Depreciated Assets							73
74	Alloc. - SIR / Generations	45,287						74
75	TOTALS	$ 1,399,239	$	$	$		$	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	Facility	2012 Dodge Minivan	2012	$ 19,000	$	$	$		$	76
77	Alloc. - SIR / Generations			1,176						77
78										78
79										79
80	TOTALS			$ 20,176	$	$	$		$	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)	$ 14,631,975	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 241,156	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 241,156	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,554,767	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/16 Ending: 12/31/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - Related Party

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. [X] 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	See Suppl				0			5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2017	$
13.	/2018	$
14.	/2019	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 3,014 Description: See Supplemental 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	Alloc. - SIR/Generation		$	$ 2,164	17
18					18
19					19
20					20
21	TOTAL		$	$ 2,164	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Generations at Neighbors
Medicaid Cost Report
01/01/16 - 12/31/16

Page 14 Supplemental Schedule

Desciption	Amount	Total
Building Rental		
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
Total	-	-
Equipment Rental		
Ecolab - Water System	1,369	1,369
Toshiba - Copier	1,250	1,250
Alloc. - SIR Mgmt. / Generations HCN	396	396
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
Total	3,014	3,014

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' PREPARATION REPORT

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 115,114	$		$ 115,114	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			17,471			17,471	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			103,111			103,111	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				57,818		57,818	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					0			12
13	Other (specify): See Supplemental	39 - 03				8,495			8,495	13
14	TOTAL			$		$ 244,191	$ 57,818		$ 302,009	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Generations at Neighbors
Medicaid Cost Report
01/01/16 - 12/31/16

Page 16 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Radiology			3,115	3,115
Laboratory			5,117	5,117
Other			263	263
				-
				-
				-
				-
				-
				-
				-
				-
				-
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				-
				-
				-
				-
Total	-	-	8,495	8,495

STATE OF ILLINOIS

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/16 Ending: 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/16 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 13,578	$ 819,064	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 150,000)	1,036,043	1,036,043	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,666	24,666	6
7	Other Prepaid Expenses	12,670	14,659	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,086,957	$ 1,894,432	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		170,000	13
14	Buildings, at Historical Cost		2,480,000	14
15	Leasehold Improvements, at Historical Cost	486,360	10,813,108	15
16	Equipment, at Historical Cost	240,667	1,013,059	16
17	Accumulated Depreciation (book methods)	(233,878)	(1,483,790)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	1,784,025	1,037,490	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,277,174	$ 14,029,867	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,364,131	$ 15,924,299	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 318,490	$ 741,293	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	874,430	874,430	29
30	Accrued Salaries Payable	112,230	112,230	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,202	4,202	31
32	Accrued Real Estate Taxes(Sch.IX-B)		67,000	32
33	Accrued Interest Payable		67,286	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	8,500	8,500	35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	1,805,000	2,405,000	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,122,852	$ 4,279,941	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,635,822	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 11,635,822	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,122,852	$ 15,915,763	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 241,279	$ 8,536	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,364,131	$ 15,924,299	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Generations at Neighbors
Medicaid Cost Report
01/01/16 - 12/31/16

Page 17 Supplemental Schedule

Description		Operating		Building		Total
Line 9 - Other Current Assets						
						-
						-
						-
						-
						-
Sub-Total		-		-		-
Line 23 - Long Term Assets						
Other Deposits		83,800				83,800
Due from Neighbors Property, LLC		1,700,225		(1,700,225)		0
Goodwill / CON Costs				744,884		744,884
Loan Costs (Net of Amortization)				208,806		208,806
			-			-
Sub-Total		1,784,025		(746,535)		1,037,490
Line 36 - Other Current Liability						
Shareholder Loans		1,805,000		600,000		2,405,000
						-
						-
						-
						-
Sub-Total		1,805,000		600,000		2,405,000
Line 43 - Long term Liabilities						
						-
						-
						-
						-
						-
Sub-Total		-		-		-

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 629,889	1
2	Restatements (describe):		2
3	**Rounding**	(1)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 629,888	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(388,609)	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)**	$ (388,609)	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)**	$ 241,279	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,417,046	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,417,046	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	65,769	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 65,769	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	12,564	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 12,564	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	19,851	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 19,851	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	25	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 25	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,515,255	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	990,721	31
32	Health Care	1,835,141	32
33	General Administration	1,123,675	33
	B. Capital Expense		
34	Ownership	390,924	34
	C. Ancillary Expense		
35	Special Cost Centers	369,921	35
36	Provider Participation Fee	193,482	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,903,864	40
41	**Income before Income Taxes (line 30 minus line 40)****	(388,609)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (388,609)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,542,117	44
45	Private Pay - Net Inpatient Revenue	543,720	45
46	Medicare - Net Inpatient Revenue	739,854	46
47	Other-(specify) Insurance - Net Inpatient Revenue	292,357	47
48	Other-(specify) Veterans and Hospice - Net Inpatient Revenue	298,998	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,417,046	49

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Generations at Neighbors
Medicaid Cost Report
01/01/16 - 12/31/16

Page 19 Supplemental Schedule

Description		Amount		Total
Jury Duty Income (Page 5 Adjustment)		25		25
				-
				-
				-
				-
				-
				-
				-
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				-
Total		25		25

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,159	2,284	$ 80,308	$ 35.16	1
2	Assistant Director of Nursing	910	1,255	35,888	28.60	2
3	Registered Nurses	3,743	3,992	103,128	25.83	3
4	Licensed Practical Nurses	7,852	8,439	196,900	23.33	4
5	CNAs & Orderlies	38,093	40,689	493,544	12.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,513	5,881	83,711	14.23	8
9	Activity Director					9
10	Activity Assistants	7,355	7,834	90,280	11.52	10
11	Social Service Workers	5,286	5,747	72,686	12.65	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,583	21,362	229,837	10.76	15
16	Dishwashers					16
17	Maintenance Workers	2,007	2,143	31,379	14.64	17
18	Housekeepers	10,405	11,214	124,124	11.07	18
19	Laundry	6,793	7,384	83,614	11.32	19
20	Administrator	1,858	2,091	91,475	43.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,186	7,660	134,696	17.58	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					31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	6,362	6,851	128,217	18.72	33
34	TOTAL (lines 1 - 33)	125,105	134,826	$ 1,979,787 *	$ 14.68	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 9,308	01 - 03	35
36	Medical Director		17,400	09 - 03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,436	10 - 03	39
40	Physical Therapy Consultant		65	10A - 03	40
41	Occupational Therapy Consultant		98	10A - 03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant		573	10A - 03	43
44	Activity Consultant		1,747	11 - 03	44
45	Social Service Consultant		1,747	12 - 03	45
46	Other(specify)				46
47	See Supplemental Schedule		53,328		47
48					48
49	TOTAL (lines 35 - 48)		$ 85,702		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	4,635	$ 191,513	10 - 03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	9,402	231,048	10 - 03	52
53	TOTAL (lines 50 - 52)	14,037	$ 422,561		53

Generations at Neighbors
Medicaid Cost Report
01/01/16 - 12/31/16

Page 20 Supplemental Schedule

Nursing Home Employees

Description	CC Reference	Hours Worked	Hours Paid	Salary	Average Rate	Hours Paid	Contracted Cost
					-		
MDS Coordinator / Medical Records	10	3,839	4,161	80,909	19.44		
Marketing	43	2,523	2,690	47,308	17.59		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
Total		6,362	6,851	128,217	37.03		

Contracted Services

Alloc - SIR / Generations HCN				
Dietary Consultant	01			12,120
Nursing Consultant	10			31,512
Rehab Consultant	10A			9,696
Total			-	53,328

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Pawn Thammarath	Administrator	0	$ 91,475
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 91,475

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SIR Mgmt / Generations HCN	Bookkeeping Services	$ 52,116
SIR Mgmt / Generations HCN	Financial Services	39,600
SIR Mgmt / Generations HCN	Adminsitrative Services	29,088
SIR Mgmt / Generations HCN	Ancillary Admin Services	24,240
SIR Mgmt / Generations HCN	Reimbursement	14,544
SIR Mgmt / Generations HCN	Regulatory Services	14,544
SIR Mgmt / Generations HCN	Computer Support Charges	13,332
Plante & Moran, PLLC	Accounting Fees	13,175
Marcum, LLP	Accounting Fees	4,650
Pension Specialists	401k Plan	3,680
Paychex	Payroll Service	8,760
See Supplemental Schedule		38,768
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 256,498

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 44,611
Unemployment Compensation Insurance	35,630
FICA Taxes	145,521
Employee Health Insurance	74,133
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	23,932
Life Insurance	142
Retirement Benefits	5,832
TOTAL (agree to Schedule V, line 22, col.8)	$ 329,802

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,992
Advertising: Employee Recruitment	10,655
Health Care Worker Background Check	2,060
(Indicate # of checks performed)	
Patient Background Checks	
Licenses and Permits	3,746
Dues and Subscriptions	6,801
Association Dues - ICLTC	13,233
Advertising and Promotion	42,674
Alloc - SIR Mgmt / Gen. HCN	2,695
Less: Public Relations Expense	( )
Non-allowable advertising	(42,674)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 41,182

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,879
Alloc - SIR Mgmt / Gen. HCN	235
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,114

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Generations at Neighbors
Medicaid Cost Report
01/01/16 - 12/31/16

Page 21 Supplemental Schedule - Other Professional Fees

Vendor	Service Description	Amount	Total
HK Payroll	WOTC Program	827	827
Personnel Planners	Unemployment Tax Consultant	988	988
OnShift Inc	Payroll Service	1,639	1,639
Seyfarth Shaw, LLP	Legal Fees	3,500	3,500
Laner Muchin	Legal Fees	951	951
Amedo Greco	Legal Fees	700	700
Lawrence Swartz	Legal Fees	584	584
Burke, Warren, MacKay & Serritella, PC	Legal Fees	414	414
Neal, Gerber & Eisenberg, LLP	Legal Fees	9,090	9,090
Non-Allowable Legal Collections	Legal - Collection	4,424	4,424
Pinnacle	Customer Satisfaction	1,758	1,758
E-Health	Computer Services	3,300	3,300
Yngve & Associates	Other	235	235
Achieve Accredidation, LLC	Credentialing Service	10,358	10,358
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
Total		38,768	38,768

Generations at Neighbors
Medicaid Cost Report
01/01/16 - 12/31/16

Page 21 Supplemental Schedule - Legal Invoice Detail

Vendor	Service Description	Invoice Date		Amount	Non-Allowable	Allowable
Neal, Gerber, & Eisenberg LLP	General Labor and Employment Matters	01/28/16			144	(144)
Neal, Gerber, & Eisenberg LLP	General Labor and Employment Matters	01/28/16			578	(578)
Amedeo Greco	General Labor and Employment Matters	02/18/16		700		700
Neal, Gerber, & Eisenberg LLP	General Labor and Employment Matters	02/18/16		1,971		1,971
Seyfarth Shaw	Loan Agreements	02/23/16			3,500	(3,500)
Neal, Gerber, & Eisenberg LLP	General Labor and Employment Matters	03/18/16		2,992		2,992
Burke, Warren, MacKay and Serritella, P	General Corporate	04/19/16		414		414
Neal, Gerber, & Eisenberg LLP	General Labor and Employment Matters	05/11/16		1,181		1,181
Neal, Gerber, & Eisenberg LLP	General Labor and Employment Matters	05/18/16		767		767
Neal, Gerber, & Eisenberg LLP	General Labor and Employment Matters	07/21/16		196		196
Law Offices of Lawrence Schwartz	General Corporate	10/10/16		584		584
Laner Muchin	General Labor and Employment Matters	11/01/16		951		951
Neal, Gerber, & Eisenberg LLP	General Labor and Employment Matters	11/01/16		308		308
Neal, Gerber, & Eisenberg LLP	General Labor and Employment Matters	12/03/16		952		952
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
						-
Total				11,017	4,222	6,795

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/16 Ending: 12/31/16

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC - $13,233**

(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? **5 - 10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **10,583** Line **10 - 02**

(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. $ **193,482**
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.

SEE ACCOUNTANTS' PREPARATION REPORT

(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. $ **0** 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? **N/A**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
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? **Yes**
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees