FOR BHF USE

LL1

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

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

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 01/01/17 to 12/31/17 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: 01/01/17 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 _____

	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	101.00	Skilled (SNF)	101	36,865	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	36,865	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	17,244	4,892	5,561	27,697	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,244	4,892	5,561	27,697	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.13%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 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 2,352

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: 12/31/17 Fiscal Year: 12/31/17

* 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: 01/01/17 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	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	230,642	23,558	20,981	275,181		275,181	(2,721)	272,460			1
2	Food Purchase		189,590		189,590		189,590	(70)	189,520			2
3	Housekeeping	155,042		19,353	174,395		174,395	(1,310)	173,085			3
4	Laundry	85,537		31,519	117,056		117,056	(2)	117,054			4
5	Heat and Other Utilities			125,108	125,108		125,108	1,028	126,136			5
6	Maintenance	33,430	92,595		126,025		126,025	8,697	134,722			6
7	Other (specify):* See Supplemental			7,059	7,059		7,059	4,375	11,434			7
8	**TOTAL General Services**	504,651	305,743	204,020	1,014,414		1,014,414	9,997	1,024,411			8
	B. Health Care and Programs											
9	Medical Director			19,200	19,200		19,200	3,273	22,473			9
10	Nursing and Medical Records	1,175,543	26,412	700,272	1,902,227		1,902,227	4,091	1,906,318			10
10a	Therapy			432,080	432,080		432,080	(2,449)	429,631			10a
11	Activities	86,573		10,477	97,050		97,050		97,050			11
12	Social Services	78,704		1,701	80,405		80,405		80,405			12
13	CNA Training											13
14	Program Transportation			6,768	6,768		6,768		6,768			14
15	Other (specify):* See Supplemental							4,184	4,184			15
16	**TOTAL Health Care and Programs**	1,340,820	26,412	1,170,498	2,537,730		2,537,730	9,099	2,546,829			16
	C. General Administration											
17	Administrative	125,988			125,988		125,988	40,709	166,697			17
18	Directors Fees											18
19	Professional Services			346,113	346,113		346,113	(109,109)	237,004			19
20	Dues, Fees, Subscriptions & Promotions			53,003	53,003		53,003	152	53,155			20
21	Clerical & General Office Expenses	202,849	59,345	58,808	321,002		321,002	4,298	325,300			21
22	Employee Benefits & Payroll Taxes			347,829	347,829		347,829	(1,755)	346,074			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,614	8,614		8,614	92	8,706			24
25	Other Admin. Staff Transportation							5,594	5,594			25
26	Insurance-Prop.Liab.Malpractice			67,134	67,134		67,134	2,032	69,166			26
27	Other (specify):* See Supplemental	11,388		65,608	76,996		76,996	(14,229)	62,767			27
28	**TOTAL General Administration**	340,225	59,345	947,109	1,346,679		1,346,679	(72,216)	1,274,463			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,185,696	391,500	2,321,627	4,898,823		4,898,823	(53,120)	4,845,703			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, LLC
Medicaid Cost Report
01/01/17 - 12/31/17

Page 3 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 7 - Other General Services				
Trash and Refuse Removal			7,059	7,059
Alloc. - Generations HCN				-
Employee Benefits			4,375	4,375
				-
				-
				-
				-
Sub-Total	-	-	11,434	11,434
Line 15 - Other Health Care Services				
Alloc. - Generations HCN				-
Employee Benefits			4,184	4,184
				-
				-
				-
				-
				-
Sub-Total	-	-	4,184	4,184
Line 27 - Other General Administration				
Other Administrative			41,506	41,506
				-
				-
Alloc. - Generations HCN				-
Employee Benefits			21,261	21,261
				-
				-
Sub-Total	-	-	62,767	62,767

Facility Name & ID Number Generations at Neighbors #0049973 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			40,600	40,600		40,600	486,203	526,803			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			137,635	137,635		137,635	771,616	909,251			32
33	Real Estate Taxes			63,600	63,600		63,600	12,416	76,016			33
34	Rent-Facility & Grounds			957,000	957,000		957,000	(957,000)				34
35	Rent-Equipment & Vehicles			30,670	30,670		30,670	2,522	33,192			35
36	Other (specify):* Sales Tax			625	625		625	(625)				36
37	**TOTAL Ownership**			1,230,130	1,230,130		1,230,130	315,132	1,545,262			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	107,264	71,892	126,512	305,668		305,668	(4,905)	300,763			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			209,142	209,142		209,142		209,142			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	107,264	71,892	335,654	514,810		514,810	(4,905)	509,905			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,292,960	463,392	3,887,411	6,643,763		6,643,763	257,107	6,900,870			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

Facility Name & ID Number Generations at Neighbors # 0049973 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.)

	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	(70)	2		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		32		10
11	Discounts, Allowances, Rebates & Refunds		21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(625)	36		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(42,269)	21		24
25	Fund Raising, Advertising and Promotional	(35,490)	27		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	(90,622)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (169,076)		$	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)	385,826	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 385,826		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 216,750		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: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Independent Living	$ 0	43	1
2	Non-Allowable Benefits (Marketing & ILU)	(1,727)	22	2
3	Legal Fees - Collections	(4,853)	19	3
4	Bank Fees	(12,230)	21	4
5		0		5
6		0		6
7		0		7
8		0		8
9		0		9
10		0		10
11		0		11
12	Neighbors Property, LLC - Non Allowable	0		12
13	Professional Fees	(20,660)	19	13
14	Dues and Subscriptions	(995)	20	14
15	Office and Clerical	(44)	21	15
16	Amortization	(50,113)	31	16
17		0		17
18		0		18
19		0		19
20		0		20
21		0		21
22		0		22
23		0		23
24		0		24
25		0		25
26		0		26
27		0		27
28		0		28
29		0		29
30		0		30
31		0		31
32		0		32
33		0		33
34		0		34
35		0		35
36		0		36
37		0		37
38		0		38
39		0		39
40		0		40
41		0		41
42		0		42
43		0		43
44		0		44
45		0		45
46		0		46
47		0		47
48		0		48
49	**Total**	(90,622)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Generations at Neighbors # 0049973 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 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	(2,721)	0	0	0	0	0	0	0	(2,721)	1
2	Food Purchase	(70)	0	0	0	0	0	0	0	0	0	0	(70)	2
3	Housekeeping	0	0	0	0	(1,310)	0	0	0	0	0	0	(1,310)	3
4	Laundry	0	0	0	0	(2)	0	0	0	0	0	0	(2)	4
5	Heat and Other Utilities	0	0	0	1,028	0	0	0	0	0	0	0	1,028	5
6	Maintenance	0	8,690	(949)	1,066	(110)	0	0	0	0	0	0	8,697	6
7	Other (specify):*	0	0	663	3,712	0	0	0	0	0	0	0	4,375	7
8	**TOTAL General Services**	(70)	8,690	(286)	3,085	(1,422)	0	0	0	0	0	0	9,997	8
	B. Health Care and Programs													
9	Medical Director	0	0	3,273	0	0	0	0	0	0	0	0	3,273	9
10	Nursing and Medical Records	0	0	6,125	4,288	(4,975)	(1,347)	0	0	0	0	0	4,091	10
10a	Therapy	0	0	0	(2,449)	0	0	0	0	0	0	0	(2,449)	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	2,933	1,251	0	0	0	0	0	0	0	4,184	15
16	**TOTAL Health Care and Programs**	0	0	12,331	3,090	(4,975)	(1,347)	0	0	0	0	0	9,099	16
	C. General Administration													
17	Administrative	0	0	(16,014)	56,723	0	0	0	0	0	0	0	40,709	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(25,513)	20,660	(112,283)	8,027	0	0	0	0	0	0	0	(109,109)	19
20	Fees, Subscriptions & Promotions	(995)	995	152	0	0	0	0	0	0	0	0	152	20
21	Clerical & General Office Expenses	(54,543)	44	58,718	82	0	(3)	0	0	0	0	0	4,298	21
22	Employee Benefits & Payroll Taxes	(1,727)	0	0	0	(28)	0	0	0	0	0	0	(1,755)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	92	0	0	0	0	0	0	0	0	92	24
25	Other Admin. Staff Transportation	0	0	5,594	0	0	0	0	0	0	0	0	5,594	25
26	Insurance-Prop.Liab.Malpractice	0	991	934	107	0	0	0	0	0	0	0	2,032	26
27	Other (specify):*	(35,490)	0	7,289	13,972	0	0	0	0	0	0	0	(14,229)	27
28	**TOTAL General Administration**	(118,268)	22,690	(55,518)	78,911	(28)	(3)	0	0	0	0	0	(72,216)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(118,338)	31,380	(43,473)	85,086	(6,425)	(1,350)	0	0	0	0	0	(53,120)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Generations at Neighbors # 0049973 **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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	482,575	0	3,628	0	0	0	0	0	0	0	486,203	30
31	Amortization of Pre-Op. & Org.	(50,113)	50,113	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	770,861	(2,269)	3,024	0	0	0	0	0	0	0	771,616	32
33	Real Estate Taxes	0	7,897	0	4,519	0	0	0	0	0	0	0	12,416	33
34	Rent-Facility & Grounds	0	(957,000)	0	0	0	0	0	0	0	0	0	(957,000)	34
35	Rent-Equipment & Vehicles	0	0	2,522	0	0	0	0	0	0	0	0	2,522	35
36	Other (specify):*	(625)	0	0	0	0	0	0	0	0	0	0	(625)	36
37	**TOTAL Ownership**	(50,738)	354,446	253	11,171	0	0	0	0	0	0	0	315,132	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	(4,905)	0	0	0	0	0	(4,905)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	(4,905)	0	0	0	0	0	(4,905)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(169,076)	385,826	(43,220)	96,257	(6,425)	(6,255)	0	0	0	0	0	257,107	45

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 957,000	Neighbors Property, LLC	100.00%	$	$ (957,000)	1
2	V	33	Real Estate Taxes	63,600	Neighbors Property, LLC	100.00%		(63,600)	2
3	V	6	Maintenance		Neighbors Property, LLC	100.00%	8,690	8,690	3
4	V	19	Professional Fees		Neighbors Property, LLC	100.00%	20,660	20,660	4
5	V	20	Dues and Subscriptions		Neighbors Property, LLC	100.00%	995	995	5
6	V	21	Office and Clerical		Neighbors Property, LLC	100.00%	44	44	6
7	V	26	Insurance		Neighbors Property, LLC	100.00%	991	991	7
8	V	30	Depreciation		Neighbors Property, LLC	100.00%	482,575	482,575	8
9	V	31	Amortization		Neighbors Property, LLC	100.00%	50,113	50,113	9
10	V	32	Interest		Neighbors Property, LLC	100.00%	770,861	770,861	10
11	V	33	Real Estate Taxes		Neighbors Property, LLC	100.00%	71,497	71,497	11
12	V								12
13	V								13
14	Total			$ 1,020,600			$ 1,406,426	$ * 385,826	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: 01/01/17 Ending: 12/31/17

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: 01/01/17 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. [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	$ 8,041	Generations HC Network, LLC	100.00%	$ 7,092	$ (949)	15
16	V	7	EMP. BEN.-GEN. SERV.		Generations HC Network, LLC	100.00%	663	663	16
17	V	9	Medical Director		Generations HC Network, LLC	100.00%	3,273	3,273	17
18	V	10	Nursing	17,400	Generations HC Network, LLC	100.00%	23,525	6,125	18
19	V	15	Emp. Ben. - Health Care		Generations HC Network, LLC	100.00%	2,933	2,933	19
20	V	17	Administrative	29,549	Generations HC Network, LLC	100.00%	13,535	(16,014)	20
21	V	19	Professional Fees	113,137	Generations HC Network, LLC	100.00%	854	(112,283)	21
22	V	20	Dues, Fees, and Subscriptions		Generations HC Network, LLC	100.00%	152	152	22
23	V	21	Office and Clerical	14,844	Generations HC Network, LLC	100.00%	73,562	58,718	23
24	V	24	Education and Seminar		Generations HC Network, LLC	100.00%	92	92	24
25	V	25	Other Admin. Staff Transportation		Generations HC Network, LLC	100.00%	5,594	5,594	25
26	V	26	Insurance		Generations HC Network, LLC	100.00%	934	934	26
27	V	27	Emp. Ben. - Gen. Administration		Generations HC Network, LLC	100.00%	7,289	7,289	27
28	V	32	Interest		Generations HC Network, LLC	100.00%	(2,269)	(2,269)	28
29	V	35	Rental - Auto		Generations HC Network, LLC	100.00%	2,068	2,068	29
30	V	35	Rental - Equipment		Generations HC Network, LLC	100.00%	454	454	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			$ 182,971			$ 139,751	$ * (43,220)	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: 01/01/17 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. [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	$ 6,695	Generations HC Network, LLC	100.00%	$ 3,974	$ (2,721)	15
16	V	7	Emp. Ben. - Gen. Services		Generations HC Network, LLC	100.00%	688	688	16
17	V	10	Nursing		Generations HC Network, LLC	100.00%	4,288	4,288	17
18	V	15	Emp. Ben. - Health Care		Generations HC Network, LLC	100.00%	740	740	18
19	V	17	Administration		Generations HC Network, LLC	100.00%	56,723	56,723	19
20	V	19	Professional Fees		Generations HC Network, LLC	100.00%	7,982	7,982	20
21	V	27	Emp. Ben. - Gen. Administration		Generations HC Network, LLC	100.00%	13,972	13,972	21
22	V								22
23	V	10A	Rehab	5,382	Generations HC Network, LLC	100.00%	2,933	(2,449)	23
24	V	15	Emp. Ben. - Health Care		Generations HC Network, LLC	100.00%	511	511	24
25	V								25
26	V	6	Maintenance	16,227	Generations HC Network, LLC	100.00%	16,649	422	26
27	V	7	Emp. Ben. - Gen. Services		Generations HC Network, LLC	100.00%	3,024	3,024	27
28	V								28
29	V	5	Utilities		Generations HC Network, LLC	100.00%	1,028	1,028	29
30	V	6	Maintenance		Generations HC Network, LLC	100.00%	644	644	30
31	V	19	Professional Fees		Generations HC Network, LLC	100.00%	45	45	31
32	V	21	Office and Cliercal		Generations HC Network, LLC	100.00%	82	82	32
33	V	26	Insurance		Generations HC Network, LLC	100.00%	107	107	33
34	V	30	Depreciation		Generations HC Network, LLC	100.00%	3,628	3,628	34
35	V	32	Interst		Generations HC Network, LLC	100.00%	3,024	3,024	35
36	V	33	Real Estate Taxes		Generations HC Network, LLC	100.00%	4,519	4,519	36
37	V								37
38	V								38
39	Total			$ 28,304			$ 124,561	$ * 96,257	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: 01/01/17 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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Big Ten Supply, LLC	100.00%	$	$	15
16	V	3	Housekeeping	15,117	Big Ten Supply, LLC	100.00%	13,807	(1,310)	16
17	V	4	Laundry	20	Big Ten Supply, LLC	100.00%	18	(2)	17
18	V	6	Maintenance	1,274	Big Ten Supply, LLC	100.00%	1,164	(110)	18
19	V	10	Nursing	57,390	Big Ten Supply, LLC	100.00%	52,415	(4,975)	19
20	V	10A	Rehab		Big Ten Supply, LLC	100.00%			20
21	V	22	Employee Benefits	324	Big Ten Supply, LLC	100.00%	296	(28)	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			$ 74,125			$ 67,700	$ * (6,425)	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: 01/01/17 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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance	$	Max RC, LLC	100.00%	$	$	15
16	V	10	Nursing and Medical Records	16,303	Max RC, LLC	100.00%	14,956	(1,347)	16
17	V	10A	Therapy		Max RC, LLC	100.00%			17
18	V	19	Professional Services		Max RC, LLC	100.00%			18
19	V	21	Clerical & General Office Expense	33	Max RC, LLC	100.00%	30	(3)	19
20	V	22	Employee Benefits		Max RC, LLC	100.00%			20
21	V	39	Ancillary	59,382	Max RC, LLC	100.00%	54,477	(4,905)	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			$ 75,718			$ 69,463	$ * (6,255)	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: 01/01/17 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	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	1.4	4.00	Salary	$ 7,982	17 - 7	1
2	Sarah Barrish	Relative	Administrative	0.000%	See Attachment	2	4.00	Salary	4,980	17 - 7	2
3	Kristen Schloss	Relative	Maintenance	0.000%	See Attachment	2	4.00	Salary	3,797	6 - 7	3
4	Michael Giannini	Relative	Administrative	0.000%	See Attachment	1.4	4.00	Salary	6,785	17 - 7	4
5	Nenita Guzman	Relative	Dietary	0.000%	See Attachment	2	4.00	Salary	3,974	1 - 7	5
6	Thomas Winter	Owner	Administrative	1.940%	See Attachment	2.39	4.00	Salary	7,982	17 - 7	6
7	Elka Abramchick	Relative	Clerical	0.000%	See Attachment	1.28	4.00	Salary	1,819	21-7	7
8	Joey Abramchik	Relative	Administrative	0.000%	See Attachment	1.6	4.00	Salary	7,982	17-7	8
9	Louise Bergthold	Relative	Administrative	0.000%	See Attachment	2.39	4.00	Salary	7,982	17-7	9
10	Thomas Bergthold	Relative	Clerical	0.000%	See Attachment	1.6	4.00	Salary	1,664	21-7	10
11	Andrew Chin	Relative	Clerical	0.000%	See Attachment	1.6	4.00	Salary	3,216	21-7	11
12	Fay Chin	Relative	Nursing	0.000%	See Attachment	1.6	4.00	Salary	4,288	10-7	12
13								TOTAL	$ 62,451		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: 01/01/17 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	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	Patricia McDiarmid	Relative	Administrative	0.000%	See Attachment	2	4.00	Salary	$ 5,314	17-7	1
2	Jeff Oravec	Relative	Administrative	0.000%	See Attachment	1.6	4.00	Salary	5,553	17-7	2
3	Kim Shelton	Relative	Clerical	0.000%	See Attachment	1.8	4.00	Salary	3,033	21-7	3
4	Lynn Ethell	Relative	Clerical	0.000%	See Attachment	1.2	4.00	Salary	1,975	21-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 15,875		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: 01/01/17 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 [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: 01/01/17 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 [X] NO [ ]

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

Name of Related Organization: Generations HC Network, LLC
Street Address: 6840 N. Lincoln
City / State / Zip Code: Lincolnwood, 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	693,985	14	$ 177,702	$ 95,737	27,697	$ 7,092	1
2	7	EMP BEN.-GEN.SERV.	Patient Days	693,985	14	16,617		27,697	663	2
3	9	Medical Director	Patient Days	693,985	14	82,000		27,697	3,273	3
4	10	Nursing	Patient Days	693,985	14	589,441	589,441	27,697	23,525	4
5	15	Emp. Ben. - Health Care	Patient Days	693,985	14	73,484		27,697	2,933	5
6	17	Administrative	Patient Days	693,985	14	339,126	339,126	27,697	13,535	6
7	19	Professional Fees	Patient Days	693,985	14	21,409		27,697	854	7
8	20	Dues, Fees, and Subscriptions	Patient Days	693,985	14	3,801		27,697	152	8
9	21	Office and Clerical	Patient Days	693,985	14	1,843,191	1,656,700	27,697	73,562	9
10	24	Education and Seminar	Patient Days	693,985	14	2,295		27,697	92	10
11	25	Other Admin. Staff Transp.	Patient Days	693,985	14	140,164		27,697	5,594	11
12	26	Insurance	Patient Days	693,985	14	23,394		27,697	934	12
13	27	Emp. Ben. - Gen. Admin.	Patient Days	693,985	14	182,645		27,697	7,289	13
14	32	Interest	Patient Days	693,985	14	(56,845)		27,697	(2,269)	14
15	35	Rental - Auto	Patient Days	693,985	14	51,827		27,697	2,068	15
16	35	Rental - Equipment	Patient Days	693,985	14	11,377		27,697	454	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,501,628	$ 2,681,004		$ 139,751	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Generations at Neighbors # 0049973 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 [X] NO [ ]

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

Name of Related Organization: Generations HC Network, LLC
Street Address: 6840 N. Lincoln
City / State / Zip Code: Lincolnwood, 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	693,985	14	$ 99,579	$ 99,579	27,697	$ 3,974	1
2	7	Emp. Ben. - Gen. Services	Patient Days	693,985	14	17,250		27,697	688	2
3	10	Nursing	Patient Days	693,985	14	107,435	107,435	27,697	4,288	3
4	15	Emp. Ben. - Health Care	Patient Days	693,985	14	18,544		27,697	740	4
5	17	Administration	Patient Days	693,985	14	1,421,258	1,421,258	27,697	56,723	5
6	19	Professional Fees	Patient Days	693,985	14	200,000		27,697	7,982	6
7	27	Emp. Ben. - Gen. Admin.	Patient Days	693,985	14	350,079		27,697	13,972	7
8										8
9	10A	Rehab	Special Rehab	329,142	13	179,343	179,343	5,382	2,933	9
10	15	Emp. Ben. - Health Care	Special Rehab	329,142	13	31,236		5,382	511	10
11										11
12	6	Maintenance	Maintenance	366,497	14	376,026	376,026	16,227	16,649	12
13	7	Emp. Ben. - Gen. Services	Maintenance	366,497	14	68,296		16,227	3,024	13
14										14
15	5	Utilities	Alloc. Square Feet	12,877	14	25,758		514	1,028	15
16	6	Maintenance	Alloc. Square Feet	12,877	14	16,130		514	644	16
17	19	Professional Fees	Alloc. Square Feet	12,877	14	1,139		514	45	17
18	21	Office and Cliercal	Alloc. Square Feet	12,877	14	2,063		514	82	18
19	26	Insurance	Alloc. Square Feet	12,877	14	2,682		514	107	19
20	30	Depreciation	Alloc. Square Feet	12,877	14	90,892		514	3,628	20
21	32	Interst	Alloc. Square Feet	12,877	14	75,767		514	3,024	21
22	33	Real Estate Taxes	Alloc. Square Feet	12,877	14	113,223		514	4,519	22
23										23
24										24
25	TOTALS					$ 3,196,700	$ 2,183,641		$ 124,561	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Generations at Neighbors # 0049973 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 [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			$	$		$	1
2	3	Housekeeping	Direct Allocation						13,807	2
3	4	Laundry	Direct Allocation						18	3
4	6	Maintenance	Direct Allocation						1,164	4
5	10	Nursing	Direct Allocation						52,415	5
6	10A	Rehab	Direct Allocation							6
7	22	Employee Benefits	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					$	$		$ 67,700	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Generations at Neighbors # 0049973 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 [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	06	Maintenance	Direct Allocation			$	$		$	1
2	10	Nursing and Medical Records	Direct Allocation						14,956	2
3	10A	Therapy	Direct Allocation							3
4	19	Professional Services	Direct Allocation							4
5	21	Clerical & General Office Expense	Direct Allocation						30	5
6	22	Employee Benefits	Direct Allocation							6
7	39	Ancillary	Direct Allocation						54,477	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					$	$		$ 69,463	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Generations at Neighbors # 0049973 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** 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	$ 11,899,000		5.5000	$ 770,861	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Private Bank		X	Line of Credit				600,000			27,000	6
7	Private Bank		X	Van							15	7
8	Shareholder Loans	X		Line of Credit				3,760,000			108,351	8
9	TOTAL Facility Related						$ 11,635,822	$ 16,259,000			$ 906,227	9
	B. Non-Facility Related*											
10	Alloc. SIR / Generations	X									3,024	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 3,024	14
15	TOTALS (line 9+line14)						$ 11,635,822	$ 16,259,000			$ 909,251	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:** 01/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	67,000	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.)	$	68,016	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,016	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	75,000	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.	$	76,016	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	58,482	8
	2013	59,072	9
	2014	59,839	10
	2015	64,236	11
	2016	67,798	12

Real Estate Tax Accrual = $63,600

Alloc. SIR Management = $4,519

	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:

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

2016 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 2016 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 2016.

	(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	$ 63,497.12	$ 63,497.12
2.	Alloc. - SIR Management	Long Term Care Facility	$ 102,606.43	$ 4,095.65
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 166,103.55	$ 67,592.77

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 01/01/17 Ending: 12/31/17

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: 01/01/17 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 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	Landmark Construction - Skylight Smoke Detector			2017	8,800						27
28											28
29	Neighbors Property, LLC										29
30	Drywall / Hallways 100 & 400			2014	44,751						30
31	Drywall / Hallways 200 & 300			2015	43,700						31
32	Construction - Bed Addition (30) Building Demolition and Rebuild			2016	10,179,462						32
33	Landmark Construction - Additional project work			2017	84,052						33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Generations at Neighbors # 0049973 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	
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)		$ 13,066,085	$		$	$	$	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: 01/01/17 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		$ 13,066,085	$		$	$	$	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)		$ 13,135,412	$		$	$	$	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: 01/01/17 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 12B, Carried Forward		$ 13,135,412	$		$	$	$	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			31,719		31,719		274,478	30
31	FS Depreciation - Neighbors Properties, LLC			482,575		482,575		1,732,487	31
32	FS Depreciation - SIR Mgmt / Generations HC Network, LLC			5,872		5,872		75,449	32
33									33
34	TOTAL (lines 1 thru 33)		$ 13,135,412	$ 520,166		$ 520,166	$	$ 2,082,414	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: 01/01/17 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	$ 1,353,952	$	$	$		$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Alloc. - SIR / Generations							74
75	TOTALS	$ 1,353,952	$	$	$		$	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)	$ 14,679,540	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 520,166	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 520,166	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)	$ 2,082,414	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Generations at Neighbors # 0049973 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 - 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. ☐ 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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 454 Description: Rental Moveable Equipment
(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		$	$ 2,068	17
18					18
19					19
20					20
21	TOTAL		$	$ 2,068	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

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	V10A	hrs	$ 0		$ 169,782	$ 0		$ 169,782	1
2	Licensed Speech and Language Development Therapist	V10A	hrs	0		10,968	0		10,968	2
3	Licensed Recreational Therapist	V10A	hrs	0	0	0	0			3
4	Licensed Physical Therapist	V10A	hrs	0		248,881	0		248,881	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	V39	##### hrs	107,264	0	0	0	5,399	107,264	8
9	Pharmacy	V39	# of prescrpts	0	0	0	110,314		110,314	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LAB/RADIOLOGY	V39		0	0	0	11,293		11,293	12
13	Other (specify): BILLABLE SUPPLIES	V39		0	0	0	71,892		71,892	13
14	TOTAL			$ 107,264		$ 429,631	$ 193,499	5,399	$ 730,394	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

STATE OF ILLINOIS

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 82,317	$ 887,803	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	906,618	906,618	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	52,451	52,451	6
7	Other Prepaid Expenses	1,988	1,988	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	9,511		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,052,885	$ 1,848,860	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	495,160	10,906,040	15
16	Equipment, at Historical Cost	263,586	1,035,978	16
17	Accumulated Depreciation (book methods)	(274,478)	(2,006,965)	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):	1,939,586	1,939,586	22
23	Other(specify):	83,800	83,800	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,507,654	$ 14,608,439	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,560,539	$ 16,457,299	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 310,354	$ 495,447	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	3,760,000	3,760,000	29
30	Accrued Salaries Payable	120,789	120,789	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,738	5,738	31
32	Accrued Real Estate Taxes(Sch.IX-B)		75,000	32
33	Accrued Interest Payable		64,776	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	28,049	28,049	35
	Other Current Liabilities(specify):			
36				36
37		82,750		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,307,680	$ 4,549,799	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,899,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Tax	8,500	8,500	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 8,500	$ 11,907,500	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,316,180	$ 16,457,299	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (755,641)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,560,539	$ 16,457,299	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Generations at Neighbors **#** 0049973 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 241,279	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 241,279	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(996,920)	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)**	$ (996,920)	17
	B. Transfers (Itemize):		
18	**ILU net asset activity for the year**		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)**	$ (755,641)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/17 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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,534,209	1
2	Discounts and Allowances for all Levels	(1,208,392)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,325,817	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,181,805	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,181,805	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	70	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	111,909	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,016	19
20	Radiology and X-Ray	3,794	20
21	Other Medical Services	15,757	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 138,546	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	AL/IL	675	28
28a	Misc Revenue		28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 675	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,646,843	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,014,414	31
32	Health Care	2,537,730	32
33	General Administration	1,346,679	33
	B. Capital Expense		
34	Ownership	1,230,130	34
	C. Ancillary Expense		
35	Special Cost Centers	305,668	35
36	Provider Participation Fee	209,142	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,643,763	40
41	**Income before Income Taxes (line 30 minus line 40)****	(996,920)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (996,920)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,633,751	44
45	Private Pay - Net Inpatient Revenue	1,016,357	45
46	Medicare - Net Inpatient Revenue	1,151,716	46
47	Other-(specify) ALL OTHER SNF/SCF IP REVENUE	732,385	47
48	Other-(specify) C/A ANCILLARY ACCOUNTS	(1,208,392)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,325,817	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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

Facility Name & ID Number Generations at Neighbors # 0049973 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 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,102	1,286	$ 46,691	$ 36.31	1
2	Assistant Director of Nursing	1,564	1,616	50,885	31.49	2
3	Registered Nurses	3,869	4,007	128,625	32.10	3
4	Licensed Practical Nurses	8,764	9,360	267,297	28.56	4
5	CNAs & Orderlies	44,564	46,891	620,154	13.23	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	5,102	5,399	107,264	19.87	8
9	Activity Director	0	0	0		9
10	Activity Assistants	6,682	7,208	86,573	12.01	10
11	Social Service Workers	5,624	6,161	78,704	12.77	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	20,338	21,124	230,642	10.92	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	2,403	2,551	33,430	13.10	17
18	Housekeepers	12,397	13,379	155,042	11.59	18
19	Laundry	6,319	7,111	85,537	12.03	19
20	Administrator	2,092	2,615	125,988	48.18	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	10,997	11,959	202,849	16.96	22
23	Office Manager	0	0	0		23
24	Clerical	0	0	0		24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	3,111	3,365	61,890	18.39	31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify)	617	671	11,388	16.97	33
34	TOTAL (lines 1 - 33)	135,545	144,703	$ 2,292,959 *	$ 15.85	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		$ 20,981	V01-3	35
36	Medical Director		19,200	V09-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,588	V10-3	39
40	Physical Therapy Consultant		300	V10A-3	40
41	Occupational Therapy Consultant		180	V10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant		120	V10A-3	43
44	Activity Consultant		1,701	V11-3	44
45	Social Service Consultant		1,701	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 49,771		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	8,263	$ 409,248	V10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	10,347	281,619	V10-3	52
53	TOTAL (lines 50 - 52)	18,609	$ 690,867		53

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Pawn Thammarath	Administrator	0	$ 125,988
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 125,988

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	$ 52,908
SIR Mgmt / Generations HCN	Financial Services	40,800
SIR Mgmt / Generations HCN	Adminsitrative Services	16,087
SIR Mgmt / Generations HCN	Ancillary Admin Services	13,462
SIR Mgmt / Generations HCN	Reimbursement	14,844
SIR Mgmt / Generations HCN	Regulatory Services	8,041
SIR Mgmt / Generations HCN	Computer Support Charges	13,632
Consulting	Consulting Services	186,339
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 346,113

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 31,010
Unemployment Compensation Insurance	36,905
FICA Taxes	168,717
Employee Health Insurance	84,019
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	19,950
Life Insurance	(1,778)
Retirement Benefits	7,251
TOTAL (agree to Schedule V, line 22, col.8)	$ 346,074

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	$
Advertising: Employee Recruitment	18,349
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Licenses and Permits	
Dues and Subscriptions	19,747
Association Dues - ICLTC	12,273
Advertising and Promotion	24,102
Alloc - SIR Mgmt / Gen. HCN	
Less: Public Relations Expense	(20,614)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 53,857

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Travel	8,614
Seminar Expense	92
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,706

* Attach copy of IMRF notifications
**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Generations at Neighbors # 0049973 Report Period Beginning: 01/01/17 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. **ICLTC - $12,273**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(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. $ **13,397** 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. $ **209,142**
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? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees

PM STAFF - > COPY IN FROM TB FILE, IL MCD CR ENTRY TAB

PG 1 & 2

IDPH License ID Number:	0049973
Facility Name:	Generations at Neighbors, LLC
Street	801 West 2nd Street
City	Byron
Zip Code	61010
County	Ogle
Telephone Number:	(815) 234-2511
Fax #	(815) 234-3114
HFS ID Number:	
Date of Initial License for Current Owners:	07/10/08
VOLUNTARY,NON-PROFIT	
Charitable Corp.	
Trust	
IRS Exemption Code	
PROPRIETARY	X
Individual	
Partnership	
Corporation	
"Sub-S" Corp.	
Limited Liability Co.	X
Trust	
Other	
Other	
GOVERNMENTAL	
State	
County	
Other	
Other	
Name:	Denise A. Gadomski, CPA
Telephone Number:	(216) 274-6514
Email Address:	denise.gadomski@plantemoran.com
Beds at Beginning	
Skilled (SNF)	101
Skilled Pediatric (SNF/PED)	
Intermediate (ICF)	
Intermediate/DD	
Sheltered Care (SC)	
ICF/DD 16 or Less	
Beds at End	
Skilled (SNF)	101
Skilled Pediatric (SNF/PED)	
Intermediate (ICF)	
Intermediate/DD	
Sheltered Care (SC)	
ICF/DD 16 or Less	
Licensed Bed Days	
Skilled (SNF)	36865
Skilled Pediatric (SNF/PED)	
Intermediate (ICF)	
Intermediate/DD	
Sheltered Care (SC)	
ICF/DD 16 or Less	
MCD Census	
Skilled (SNF)	
Skilled Pediatric (SNF/PED)	17244
Intermediate (ICF)	
Intermediate/DD	
Sheltered Care (SC)	
ICF/DD 16 or Less	
Private Pay Census	
Skilled (SNF)	
Skilled Pediatric (SNF/PED)	4892
Intermediate (ICF)	
Intermediate/DD	
Sheltered Care (SC)	
ICF/DD 16 or Less	
All Other Census	
Skilled (SNF)	
Skilled Pediatric (SNF/PED)	5561
Intermediate (ICF)	
Intermediate/DD	
Sheltered Care (SC)	
ICF/DD 16 or Less	
Medicare Days	2352

PG 3 & 4

A. General Services	Salary/Wage	Supplies	Other	Reclass	Adjustment
Dietary	230642	23558	20981	0	-2721
Food Purchase	0	189590	0	0	-70
Housekeeping	155042	0	19353	0	-1310
Laundry	85537	0	31519	0	-2
Heat and Other Utilities	0	0	125108	0	1028
Maintenance	33430	92595	0	0	8697
Other (specify):*	0	0	7059	0	4375
TOTAL General Services					
B. Health Care and Programs					
Medical Director	0	0	19200	0	3273
Nursing and Medical Records	1175543	26412	700272	0	4091
Therapy	0	0	432080	0	-2449
Activities	86573	0	10477	0	0
Social Services	78704	0	1701	0	0
CNA Training	0	0	0	0	0
Program Transportation	0	0	6768	0	0
Other (specify):*	0	0	0	0	4184
TOTAL Health Care and Programs					
C. General Administration					
Administrative	125988	0	0	0	40709
Directors Fees	0	0	0	0	0
Professional Services	0	0	346113	0	-109109
Dues, Fees, Subscriptions & Promotions	0	0	53003	0	152
Clerical & General Office Expenses	202849	59345	58808	0	4298
Employee Benefits & Payroll Taxes	0	0	347829	0	-1755
Inservice Training & Education	0	0	0	0	0
Travel and Seminar	0	0	8614	0	92
Other Admin. Staff Transportation	0	0	0	0	5594
Insurance-Prop.Liab.Malpractice	0	0	67134	0	2032
Other (specify):*	11388	0	65608	0	-14229
D. Ownership					
Depreciation	0	0	40600	0	486203
Amortization of Pre-Op. & Org.	0	0	0	0	0
Interest	0	0	137635	0	771616
Real Estate Taxes	0	0	63600	0	12416
Rent-Facility & Grounds	0	0	957000	0	-957000
Rent-Equipment & Vehicles	0	0	30670	0	2522
Other (specify):*	0	0	625	0	-625
TOTAL Ownership					
Ancillary Expense					
E. Special Cost Centers					
Medically Necessary Transportation	0	0	0	0	0
Ancillary Service Centers	107264	71892	126512	0	-4905
Barber and Beauty Shops	0	0	0	0	0
Coffee and Gift Shops	0	0	0	0	0
Provider Participation Fee	0	0	209142	0	0
Other (specify):*	0	0	0	0	0

PG 5 & 5A

Day Care	0		
Other Care for Outpatients	0		
Governmental Sponsored Special Programs	0		
Non-Patient Meals	-70		
Telephone, TV & Radio in Resident Rooms	0		
Rented Facility Space	0		
Sale of Supplies to Non-Patients	0		
Laundry for Non-Patients	0		
Non-Straightline Depreciation	0		
Interest and Other Investment Income	0		
Discounts, Allowances, Rebates & Refunds	0		
Non-Working Officer's or Owner's Salary	0		
Sales Tax	-625		
Non-Care Related Interest	0		
Non-Care Related Owner's Transactions	0		
Personal Expenses (Including Transportation	0		
Non-Care Related Fees	0		
Fines and Penalties	0		
Entertainment	0		
Contributions	0		
Owner or Key-Man Insurance	0		
Special Legal Fees & Legal Retainers	0		
Malpractice Insurance for Individuals	0		
Bad Debt	-42268.98		
Fund Raising, Advertising and Promotional	-35490.09		
Property Replacement Tax	0		
CNA Training for Non-Employees	0		
Yellow Page Advertising	0		
Other-Attach Schedule	-90622		
Non-Paid Workers-Attach Schedule*	0		
Donated Goods-Attach Schedule*	0		
Pre-Operating Expense	0		
Costs (Schedule VII)	385826	VII-B	
Other- Attach Schedule	0		
PG5A Line 1	Independent Livi	0	43
PG5A Line 2	Non-Allowable B	-1727	22
PG5A Line 3	Legal Fees - Col	-4853	19
PG5A Line 4	Bank Fees	-12230	21
PG5A Line 5		0	
PG5A Line 6		0	
PG5A Line 7		0	
PG5A Line 8		0	
PG5A Line 9		0	
PG5A Line 10		0	
PG5A Line 11		0	
PG5A Line 12	Neighbors Prope	0	
PG5A Line 13	Professional I	-20660	19
PG5A Line 14	Dues and Sut	-995	20
PG5A Line 15	Office and Cl	-44	21
PG5A Line 16	Amortization	-50113	31
PG5A Line 17		0	
PG5A Line 18		0	
PG5A Line 19		0	
PG5A Line 20		0	
PG5A Line 21		0	
PG5A Line 22		0	
PG5A Line 23		0	
PG5A Line 24		0	
PG5A Line 25		0	
PG5A Line 26		0	
PG5A Line 27		0	
PG5A Line 28		0	
PG5A Line 29		0	
PG5A Line 30		0	
PG5A Line 31		0	
PG5A Line 32		0	
PG5A Line 33		0	
PG5A Line 34		0	
PG5A Line 35		0	
PG5A Line 36		0	
PG5A Line 37		0	
PG5A Line 38		0	
PG5A Line 39		0	
PG5A Line 40		0	
PG5A Line 41		0	
PG5A Line 42		0	
PG5A Line 43		0	
PG5A Line 44		0	
PG5A Line 45		0	
PG5A Line 46		0	
PG5A Line 47		0	
PG5A Line 48		0	

PG 16

Licensed Occupational Therapist	V10A
Licensed Occupational Therapist	0
Licensed Occupational Therapist	0
Licensed Occupational Therapist	#DIV/0!
Licensed Occupational Therapist	169782
Licensed Occupational Therapist	0
Licensed Speech and Language	V10A
Licensed Speech and Language	0
Licensed Speech and Language	0
Licensed Speech and Language	#DIV/0!
Licensed Speech and Language	10968
Licensed Speech and Language	0
Licensed Recreational Therapist	V10A
Licensed Recreational Therapist	0
Licensed Recreational Therapist	0
Licensed Recreational Therapist	0
Licensed Recreational Therapist	0
Licensed Recreational Therapist	0
Licensed Physical Therapist	V10A
Licensed Physical Therapist	0
Licensed Physical Therapist	0
Licensed Physical Therapist	#DIV/0!
Licensed Physical Therapist	251331
Licensed Physical Therapist	0
Habilitation	V39
Habilitation	5399.259497
Habilitation	107264
Habilitation	0
Habilitation	0
Habilitation	0
Pharmacy	V39
Pharmacy	0
Pharmacy	0
Pharmacy	0
Pharmacy	0
Pharmacy	115219
LAB/RADIOLOGY	V39
LAB/RADIOLOGY	0
LAB/RADIOLOGY	0
LAB/RADIOLOGY	0
LAB/RADIOLOGY	0
LAB/RADIOLOGY	11293
BILLABLE SUPPLIES/IV THERAPY/ETC	V39
BILLABLE SUPPLIES/IV THERAPY/ETC	0
BILLABLE SUPPLIES/IV THERAPY/ETC	0
BILLABLE SUPPLIES/IV THERAPY/ETC	0
BILLABLE SUPPLIES/IV THERAPY/ETC	0
BILLABLE SUPPLIES/IV THERAPY/ETC	71892

PG 17

Cash on Hand and in Banks	82317
Cash-Patient Deposits	0
Accounts & Short-Term Notes Receivable-	906618
Patients (less allowance	0
Supply Inventory (priced at	0
Short-Term Investments	0
Prepaid Insurance	52451
Other Prepaid Expenses	1988
Accounts Receivable (owners or related par	0
Other(specify):	9511
Long-Term Notes Receivable	0
Long-Term Investments	0
Land	0
Buildings, at Historical Cost	0
Leasehold Improvements, at Historical Cost	495160
Equipment, at Historical Cost	263586
Accumulated Depreciation (book methods)	-274478
Deferred Charges	0
Organization & Pre-Operating Costs	0
Accumulated Amortization - Organization &	0
Restricted Funds	0
Other Long-Term Assets (specify):	1939586
Other(specify):	83800
Accounts Payable	310353
Officer's Accounts Payable	0
Accounts Payable-Patient Deposits	0
Short-Term Notes Payable	3760000
Accrued Salaries Payable	120789
Accrued Taxes Payable	5738
Accrued Real Estate Taxes(Sch.IX-B)	0
Accrued Interest Payable	0
Deferred Compensation	0
Federal and State Income Taxes	28049
Other 1	0
Other 2	82750
Long-Term Notes Payable	0
Mortgage Payable	0
Bonds Payable	0
Deferred Compensation	0
Other 1	8500
Other 2	0

PG 18

Balance at Beginning of Year, as Previously	241279	
Restatement 1	0	0
Restatement 2	0	0
Restatement 3	0	0
A. Additions (deductions):		
Aquisitions of Pooled Companies	0	
Proceeds from Sale of Stock	0	
Stock Options Exercised	0	
Contributions and Grants	0	
Expenditures for Specific Purposes	0	
Dividends Paid or Other Distributions to Ow	0	
Donated Property, Plant, and Equipment	0	
Other (describe)	0	0
Other (describe)	0	0
B. Transfers (Itemize):		
Transfer1	0	ILU net asset activity for the year
Transfer2	0	0
Transfer3	0	0
Transfer4	0	0
Transfer5	0	0

Dental Receptionist — 10 Locations of Care	40 beds
Community and Government Art Of Lecture	2026/05/31
Map Color	0
Transportation Equipment	0
Therapy	4/20/1975
Oxygen	0
Programs for Education	0
Other Government Grants	0
Chair Training Rehabilitationists	0
Other Financial Agents	0
Marble and Beauty Color	0
Other Investments	0
Telephone, Telecomm and Radio	0
Department of Material	0
Sale of Crops	11/1955
Sale of Supplies to Own Patients	0
Gambling	Yes
Marketing and X-Ray	2/1/96
Lease Expenditures	jan-01
Livestock	0
Other Expenses	0
Interest and Other Investment Income**	0
Switchback Income (Insurance, Legal, Etc.)	0
Cut Hair	4/19, 6/25
Cl Index	0 Was Dreamed
Sales of Services	9/1/2018
Cl Index	0
Computer Administration	4/1/1975
Cl Index	0
Special Coin Carriers	2/1900
Property Maintenance Fee	10/2012
Cl Index	0 0
Cl Index	0 0
Cl Index	0 0
Workers Comp	0
Income Tax Rate Surplus Reserve	5/1/1914
Private Pay - Net Inpatient Revenue	9/1/1977
Private Pay - Outpatient Revenue	0
Other (specify)	730,000.00 ALL OTHER EXCEPT IF HEATED
Other (specify)	2/9/2016 10 ITS ANCILLARY ACCOUNTS
Sales	0 0 0
Director of Nursing	0.000 0.000 #DIV/0!
Other Professional Training	0.000 0.000 #DIV/0!
Registered Nurses	4.000 4.000 #DIV/0!
Other Professional Nurses	0.000 0.000 #DIV/0!
Citing of Fatalities	84,750 84,750 #DIV/0!
Child Trailhole	0 0 0
Other Fuel Used	0 0 0
Student Privacy Laws	5,142 5,396 947,196
Artillery Director	0 0 0
Other Expenditures	7,000 7,350 84,217
Social Service Workers	5,000 5,000 59,722
Cl Index	0 0
Food Service Supervisor	0 0 0
Cl Index	0 0
Grain Replacementcanada	20,158 21,213 249,000
Dishwashers	0 0 0
Other Service Workers	2,000 2,000 59,000
Housekeepers	42,000 43,575 872,000
Cl Index	0 0 0
Administration	2,000 2,000 625,000
Other Administrative	0 0 0
Other administrative	42,000 51,000 225,000
Office Manager	0 0 0
Cl Index	0 0 0
Vocational instructors	0 0 0
Academic Instructors	0 0 0
Cl Index	0 0 0
Qualified Plan (QMPP)	0 0 0
Other Professional Staff	0 0 0
Nailbeds Index (DS Yellow)	0 0 0
Cl Index	0.000 0.000 #DIV/0!
Other Health Professions(S)	0 0 0
Initial (specify)	Red 41% 41,000