

		FOR BHF USE					

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

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

<p>I. IDPH License ID Number: <u>0052910</u></p> <p>Facility Name: <u>Generations Oakton Pavillion</u></p> <p>Address: <u>1660 Oakton Place</u> <u>Des Plaines</u> <u>60018</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(847) 299-5588</u> Fax # <u>(847) 493-6525</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>09/01/14</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/17</u> to <u>12/31/17</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Type or Print Name) _____</td> </tr> <tr> <td>(Title) _____</td> </tr> <tr> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>Edward N. Slack, CPA</u> <u>Partner, Health and Human Services</u></td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>Plante & Moran, PLLC</u> <u>2155 Point Boulevard, Suite 200 Elgin, Illinois 60123</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 628 - 8796</u> Fax # <u>(248) 327 - 8417</u></td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) _____	(Title) _____	(Signed) _____	(Date) _____		(Print Name and Title) <u>Edward N. Slack, CPA</u> <u>Partner, Health and Human Services</u>		(Firm Name & Address) <u>Plante & Moran, PLLC</u> <u>2155 Point Boulevard, Suite 200 Elgin, Illinois 60123</u>		(Telephone) <u>(847) 628 - 8796</u> Fax # <u>(248) 327 - 8417</u>
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<p>In the event there are further questions about this report, please contact: Name: <u>Edward N. Slack, CPA</u> Telephone Number: <u>(847) 628 - 8796</u> Email Address: _____</p>	<p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>																																						

Facility Name & ID Number Generations Oakton Pavillion

0052910 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	294.00	Skilled (SNF)	294	107,310	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	294	TOTALS	294	107,310	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	11,834	7,100	25,959	44,893	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,834	7,100	25,959	44,893	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 41.83%

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

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

I. On what date did you start providing long term care at this location?
Date started 01/20/80

J. Was the facility purchased or leased after January 1, 1978?
YES Date 01/20/80 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 275 and days of care provided 3,693

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Generations Oakton Pavillion # 0052910 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	345,891	29,076	9,345	384,312		384,312	(17,574)	366,738		1
2	Food Purchase		319,115		319,115		319,115		319,115		2
3	Housekeeping	201,163		43,797	244,960		244,960	(4,027)	240,933		3
4	Laundry	110,096		29,235	139,331		139,331	(66)	139,265		4
5	Heat and Other Utilities			209,924	209,924		209,924	1,666	211,590		5
6	Maintenance	96,036	129,857		225,893		225,893	(14,815)	211,078		6
7	Other (specify):* See Supplemental			25,649	25,649		25,649	13,180	38,829		7
8	TOTAL General Services	753,186	478,048	317,950	1,549,184		1,549,184	(21,636)	1,527,548		8
	B. Health Care and Programs										
9	Medical Director			35,754	35,754		35,754	5,304	41,058		9
10	Nursing and Medical Records	2,932,627	58,739	306,650	3,298,016		3,298,016	(85,074)	3,212,942		10
10a	Therapy			528,560	528,560		528,560	(8,733)	519,827		10a
11	Activities	180,599		8,442	189,041		189,041		189,041		11
12	Social Services	46,896		16,448	63,344		63,344		63,344		12
13	CNA Training										13
14	Program Transportation			3,610	3,610		3,610		3,610		14
15	Other (specify):*							7,775	7,775		15
16	TOTAL Health Care and Programs	3,160,122	58,739	899,464	4,118,325		4,118,325	(80,728)	4,037,597		16
	C. General Administration										
17	Administrative	104,217			104,217		104,217	8,565	112,782		17
18	Directors Fees										18
19	Professional Services			919,517	919,517		919,517	(264,877)	654,640		19
20	Dues, Fees, Subscriptions & Promotions			35,112	35,112		35,112	246	35,358		20
21	Clerical & General Office Expenses	245,147	65,019	118,332	428,498		428,498	(9,242)	419,256		21
22	Employee Benefits & Payroll Taxes			535,002	535,002		535,002	(4,924)	530,078		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,873	4,873		4,873	148	5,021		24
25	Other Admin. Staff Transportation							9,067	9,067		25
26	Insurance-Prop.Liab.Malpractice			239,954	239,954		239,954	24,725	264,679		26
27	Other (specify):*	40,596		95,667	136,263		136,263	(64,120)	72,143		27
28	TOTAL General Administration	389,960	65,019	1,948,457	2,403,436		2,403,436	(300,412)	2,103,024		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,303,268	601,806	3,165,871	8,070,945		8,070,945	(402,776)	7,668,169		29

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

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

Generations at Oakton Pavilion, LLC
Medicaid Cost Report
01/01/17 - 12/31/17

Page 3 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 7 - Other General Services				
Scavenger Waste			25,649	25,649
Alloc. - Generations HCN				-
Employee Benefits			13,180	13,180
				-
				-
				-
Sub-Total	-	-	38,829	38,829
Line 15 - Other Health Care Services				
Alloc. - Generations HCN				-
Employee Benefits			7,775	7,775
				-
				-
				-
				-
Sub-Total	-	-	7,775	7,775
Line 27 - Other General Administration				
Other Administrative			37,682	37,682
				-
				-
Alloc. - Generations HCN				-
Employee Benefits			34,461	34,461
				-
				-
Sub-Total	-	-	72,143	72,143

Facility Name & ID Number

Generations Oakton Pavillion

#0052910

Report Period Beginning:

01/01/17

Ending:

12/31/17

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			31,619	31,619		31,619	761,851	793,470			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,264	22,264		22,264	977,790	1,000,054			32
33	Real Estate Taxes			432,000	432,000		432,000	(31,475)	400,525			33
34	Rent-Facility & Grounds			1,644,000	1,644,000		1,644,000	(1,644,000)				34
35	Rent-Equipment & Vehicles			12,418	12,418		12,418	4,089	16,507			35
36	Other (specify):*			2,203	2,203		2,203	(2,203)				36
37	TOTAL Ownership			2,144,504	2,144,504		2,144,504	66,052	2,210,556			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	133,498	82,343	146,524	362,365		362,365	(9,295)	353,070			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			400,647	400,647		400,647		400,647			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	133,498	82,343	547,171	763,012		763,012	(9,295)	753,717			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,436,766	684,149	5,857,546	10,978,461		10,978,461	(346,019)	10,632,442			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		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	(2,203)	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	(3,500)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(92,072)	21		24
25	Fund Raising, Advertising and Promotional	(95,081)	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	(527,867)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (720,723)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	526,367	VII-B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 526,367		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (194,356)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

Generations Oakton Pavillion

ID# 0052910

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)	(4,896)	22	2
3	Purchased Services - VA	(52,315)	10	3
4	Legal - Collections	(9,301)	19	4
5	Bank Fees	(7,349)	21	5
6	Theft and Damage	(434)	21	6
7		0		7
8		0		8
9		0		9
10	Generations HC Property of Des Plaines, LLC	0		10
11	Professional Fees	(17,100)	19	11
12	Dues and Subscriptions	(2,160)	20	12
13	Office and Clerical	(200)	21	13
14	Amortization	(26,170)	31	14
15	Oakton Arms	(407,941)	43	15
16		0		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	(527,866)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Generations Oakton Pavillion

0052910

Report Period Beginning:

01/01/17

Ending:

12/31/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	(17,426)	(148)	0	0	0	0	0	0	(17,574)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	(4,027)	0	0	0	0	0	0	(4,027)	3
4	Laundry	0	0	0	0	(66)	0	0	0	0	0	0	(66)	4
5	Heat and Other Utilities	0	0	0	1,666	0	0	0	0	0	0	0	1,666	5
6	Maintenance	0	0	(17,173)	2,576	(218)	0	0	0	0	0	0	(14,815)	6
7	Other (specify):*	0	0	1,075	12,105	0	0	0	0	0	0	0	13,180	7
8	TOTAL General Services	0	0	(16,098)	(1,079)	(4,459)	0	0	0	0	0	0	(21,636)	8
	B. Health Care and Programs													
9	Medical Director	0	0	5,304	0	0	0	0	0	0	0	0	5,304	9
10	Nursing and Medical Records	(52,315)	0	(23,886)	6,950	(11,154)	(4,669)	0	0	0	0	0	(85,074)	10
10a	Therapy	0	0	0	(8,733)	0	0	0	0	0	0	0	(8,733)	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	4,754	3,021	0	0	0	0	0	0	0	7,775	15
16	TOTAL Health Care and Programs	(52,315)	0	(13,828)	1,238	(11,154)	(4,669)	0	0	0	0	0	(80,728)	16
	C. General Administration													
17	Administrative	0	0	(83,374)	91,939	0	0	0	0	0	0	0	8,565	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(26,401)	17,100	(268,588)	13,012	0	0	0	0	0	0	0	(264,877)	19
20	Fees, Subscriptions & Promotions	(2,160)	2,160	246	0	0	0	0	0	0	0	0	246	20
21	Clerical & General Office Expenses	(100,055)	200	90,566	133	0	(86)	0	0	0	0	0	(9,242)	21
22	Employee Benefits & Payroll Taxes	(4,896)	0	0	0	(28)	0	0	0	0	0	0	(4,924)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	148	0	0	0	0	0	0	0	0	148	24
25	Other Admin. Staff Transportation	0	0	9,067	0	0	0	0	0	0	0	0	9,067	25
26	Insurance-Prop.Liab.Malpractice	0	23,038	1,513	174	0	0	0	0	0	0	0	24,725	26
27	Other (specify):*	(98,581)	0	11,815	22,646	0	0	0	0	0	0	0	(64,120)	27
28	TOTAL General Administration	(232,093)	42,498	(238,607)	127,904	(28)	(86)	0	0	0	0	0	(300,412)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(284,408)	42,498	(268,533)	128,063	(15,641)	(4,755)	0	0	0	0	0	(402,776)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Generations Oakton Pavillion # 0052910 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	755,971	0	5,880	0	0	0	0	0	0	0	761,851	30
31	Amortization of Pre-Op. & Org.	(26,170)	26,170	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	976,566	(3,677)	4,901	0	0	0	0	0	0	0	977,790	32
33	Real Estate Taxes	0	(38,799)	0	7,324	0	0	0	0	0	0	0	(31,475)	33
34	Rent-Facility & Grounds	0	(1,644,000)	0	0	0	0	0	0	0	0	0	(1,644,000)	34
35	Rent-Equipment & Vehicles	0	0	4,089	0	0	0	0	0	0	0	0	4,089	35
36	Other (specify):*	(2,203)	0	0	0	0	0	0	0	0	0	0	(2,203)	36
37	TOTAL Ownership	(28,373)	75,908	412	18,105	0	0	0	0	0	0	0	66,052	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	(9,295)	0	0	0	0	0	(9,295)	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):*	(407,941)	407,941	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(407,941)	407,941	0	0	0	(9,295)	0	0	0	0	0	(9,295)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(720,722)	526,347	(268,121)	146,168	(15,641)	(14,050)	0	0	0	0	0	(346,019)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 - 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. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 1,644,000	Generations Health Care Property of Des Plaines, LLC	100.00%	\$	\$ (1,644,000)	1
2	V	33 Real Estate Taxes	432,000	Generations Health Care Property of Des Plaines, LLC	100.00%		(432,000)	2
3	V	6 Maintenance		Generations Health Care Property of Des Plaines, LLC	100.00%			3
4	V	19 Professional Fees		Generations Health Care Property of Des Plaines, LLC	100.00%	17,100	17,100	4
5	V	20 Dues and Subscriptions		Generations Health Care Property of Des Plaines, LLC	100.00%	2,160	2,160	5
6	V	21 Office and Clerical		Generations Health Care Property of Des Plaines, LLC	100.00%	200	200	6
7	V	26 Insurance		Generations Health Care Property of Des Plaines, LLC	100.00%	23,038	23,038	7
8	V	30 Depreciation		Generations Health Care Property of Des Plaines, LLC	100.00%	755,971	755,971	8
9	V	31 Amortization		Generations Health Care Property of Des Plaines, LLC	100.00%	26,170	26,170	9
10	V	32 Interest		Generations Health Care Property of Des Plaines, LLC	100.00%	976,566	976,566	10
11	V	33 Real Estate Taxes		Generations Health Care Property of Des Plaines, LLC	100.00%	393,201	393,201	11
12	V	43 Oakton Arms		Generations Health Care Property of Des Plaines, LLC	100.00%	407,941	407,941	12
13	V							13
14	Total		\$ 2,076,000			\$ 2,602,347	\$ * 526,347	14

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

Facility Name & ID Number

Generations Oakton Pavillion

0052910

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	David Kozin	9.25%	Albany Care	Cook, IL	Generations Prop.	Lincolnwood, IL	Bldg. Company	2
3	Renee Kozin	9.25%	Generations at Applewood, LLC	Matteson, IL	Generations HC			3
4	Brian Barrish	14.035%	Bryn Mawr Care, Inc.	Chicago, IL	Transitions	Lincolnwood, IL	Mgmt. Company	4
5	Barrish Group	16.375%	Generations at Columbus Park, LLC	Chicago, IL	SIR Management	Lincolnwood, IL	Mgmt. Company	5
6	Ralph Gesualdo	8.188%	Decatur Manor Healthcare, LLC	Decatur, IL	SIR Properties	Lincolnwood, IL	Bldg. Company	6
7	Ralph Gesualdo Childrens Trust	8.188%	Generations at Elmwood Park, LLC	Elmwood Park, IL	Max RX, LLC	Des Plaines, IL	Pharmacy	7
8	United Trust #1	4.094%	Greenwood Care, Inc.	Evanston, IL	LTC Lab, LLC	Lincolnwood, IL	Ancillary Supplies	8
9	United Trust #2	4.094%	Maplewood Care, Inc.	Elgin, IL				9
10	LG Trust	4.094%	Generations at Neighbors, LLC	Byron, IL				10
11	BG Trust	4.094%	Generations at Oakton Pavilion, LLC	Des Plaines, IL				11
12	Burton Barrish	10.00%	Generations at Oakton Arms, LLC	Des Plaines, IL				12
13	Kirsten Barrish	1.00%	Generations at Regency, LLC	Niles, IL				13
14	Joey Abramchik	2.00%	Generations at Rock Island, LLC	Rock Island, IL				14
15	Louise Bergthold	2.00%	Auburn Village	Auburn, IL				15
16	Patrick Baalke	1.00%	Wilson Care, Inc.	Chicago, IL				16
17	Pat McDiarmid	0.34%						17
18	Thomas Winter	2.00%						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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 Maintenance	\$ 28,668	Generations HC Network, LLC	100.00%	\$ 11,495	\$ (17,173)
16	V	7 EMP. BEN.-GEN. SERV.		Generations HC Network, LLC	100.00%	1,075	1,075
17	V	9 Medical Director		Generations HC Network, LLC	100.00%	5,304	5,304
18	V	10 Nursing	62,016	Generations HC Network, LLC	100.00%	38,130	(23,886)
19	V	15 Emp. Ben. - Health Care		Generations HC Network, LLC	100.00%	4,754	4,754
20	V	17 Administrative	105,312	Generations HC Network, LLC	100.00%	21,938	(83,374)
21	V	19 Professional Fees	269,973	Generations HC Network, LLC	100.00%	1,385	(268,588)
22	V	20 Dues, Fees, and Subscriptions		Generations HC Network, LLC	100.00%	246	246
23	V	21 Office and Clerical	28,668	Generations HC Network, LLC	100.00%	119,234	90,566
24	V	24 Education and Seminar		Generations HC Network, LLC	100.00%	148	148
25	V	25 Other Admin. Staff Transportation		Generations HC Network, LLC	100.00%	9,067	9,067
26	V	26 Insurance		Generations HC Network, LLC	100.00%	1,513	1,513
27	V	27 Emp. Ben. - Gen. Administration		Generations HC Network, LLC	100.00%	11,815	11,815
28	V	32 Interest		Generations HC Network, LLC	100.00%	(3,677)	(3,677)
29	V	35 Rental - Auto		Generations HC Network, LLC	100.00%	3,353	3,353
30	V	35 Rental - Equipment		Generations HC Network, LLC	100.00%	736	736
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 494,637			\$ 226,516	\$ * (268,121)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	<u>1</u> Dietary	\$ 23,868	Generations HC Network, LLC	100.00%	\$ 6,442	\$ (17,426)
16	V	<u>7</u> Emp. Ben. - Gen. Services		Generations HC Network, LLC	100.00%	1,116	1,116
17	V	<u>10</u> Nursing		Generations HC Network, LLC	100.00%	6,950	6,950
18	V	<u>15</u> Emp. Ben. - Health Care		Generations HC Network, LLC	100.00%	1,200	1,200
19	V	<u>17</u> Administration		Generations HC Network, LLC	100.00%	91,939	91,939
20	V	<u>19</u> Professional Fees		Generations HC Network, LLC	100.00%	12,938	12,938
21	V	<u>27</u> Emp. Ben. - Gen. Administration		Generations HC Network, LLC	100.00%	22,646	22,646
22	V			Generations HC Network, LLC			
23	V	<u>10A</u> Rehab	19,188	Generations HC Network, LLC	100.00%	10,455	(8,733)
24	V	<u>15</u> Emp. Ben. - Health Care		Generations HC Network, LLC	100.00%	1,821	1,821
25	V			Generations HC Network, LLC			
26	V	<u>6</u> Maintenance	58,968	Generations HC Network, LLC	100.00%	60,501	1,533
27	V	<u>7</u> Emp. Ben. - Gen. Services		Generations HC Network, LLC	100.00%	10,989	10,989
28	V			Generations HC Network, LLC			
29	V	<u>5</u> Utilities		Generations HC Network, LLC	100.00%	1,666	1,666
30	V	<u>6</u> Maintenance		Generations HC Network, LLC	100.00%	1,043	1,043
31	V	<u>19</u> Professional Fees		Generations HC Network, LLC	100.00%	74	74
32	V	<u>21</u> Office and Clerical		Generations HC Network, LLC	100.00%	133	133
33	V	<u>26</u> Insurance		Generations HC Network, LLC	100.00%	174	174
34	V	<u>30</u> Depreciation		Generations HC Network, LLC	100.00%	5,880	5,880
35	V	<u>32</u> Interst		Generations HC Network, LLC	100.00%	4,901	4,901
36	V	<u>33</u> Real Estate Taxes		Generations HC Network, LLC	100.00%	7,324	7,324
37	V						
38	V						
39	Total		\$ 102,024			\$ 248,192	\$ * 146,168

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$ 1,709	Big Ten Supply, LLC	100.00%	\$ 1,561	\$ (148)
16	V	3 Housekeeping	46,463	Big Ten Supply, LLC	100.00%	42,436	(4,027)
17	V	4 Laundry	766	Big Ten Supply, LLC	100.00%	700	(66)
18	V	6 Maintenance	2,520	Big Ten Supply, LLC	100.00%	2,302	(218)
19	V	10 Nursing	128,676	Big Ten Supply, LLC	100.00%	117,522	(11,154)
20	V	10A Rehab		Big Ten Supply, LLC	100.00%		
21	V	22 Employee Benefits	324	Big Ten Supply, LLC	100.00%	296	(28)
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 180,458			\$ 164,817	\$ * (15,641)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10 Nursing	\$ 56,520	Max RC, LLC	100.00%	\$ 51,851	\$ (4,669)
16	V	21 Office and Clerical	1,040	Max RC, LLC	100.00%	954	(86)
17	V	22 Employee Benefits		Max RC, LLC	100.00%		
18	V	39 Ancillary	112,538	Max RC, LLC	100.00%	103,243	(9,295)
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 170,098			\$ 156,048	\$ * (14,050)

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

Facility Name & ID Number

Generations Oakton Pavillion

0052910

Report Period Beginning:

01/01/17

Ending:

12/31/17

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bryan Barrish	Shareholder	Administrative	16.370%	See Attachment	2.26	6.50	Salary	\$ 12,938	17-7	1
2	Sarah Barrish	Relative	Administrative	0.000%	See Attachment	3.23	6.50	Salary	8,072	17-7	2
3	Kirsten Schloss	Shareholder	Administrative	1.000%	See Attachment	3.23	6.50	Salary	6,155	6-7	3
4	Thomas Winter	Shareholder	Administrative	2.000%	See Attachment	3.88	6.50	Salary	12,938	17-7	4
5	Thomas Bergthold	Relative	Administrative	0.000%	See Attachment	2.59	6.50	Salary	2,697	21-7	5
6	Louise Bergthold	Shareholder	Administrative	2.000%	See Attachment	3.88	6.50	Salary	12,938	17-7	6
7	Joey Abramchik	Shareholder	Administrative	2.000%	See Attachment	2.59	6.50	Salary	12,938	17-7	7
8	Elka Abramchick	Relative	Administrative	0.000%	See Attachment	2.07	6.50	Salary	2,948	21-7	8
9	Patricia McDiarmid	Relative	Administrative	0.000%	See Attachment	3.23	6.50	Salary	8,613	17-7	9
10	Andrew Chin	Relative	Clerical	0.000%	See Attachment	2.59	6.50	Salary	5,213	21-7	10
11	Fay Chin	Relative	Nursing	0.000%	See Attachment	2.59	6.50	Salary	6,950	10-7	11
12											12
13								TOTAL	\$ 92,400		13

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

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

Facility Name & ID Number

Generations at Neighbors, LLC

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	9	
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**				
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference		
1								\$		1	
2	Jeff Oravec	Relative	Administrative	0.000%	See Attachment	2.59	6.50	Salary	9,000	17-7	2
3	Kim Shelton	Relative	Clerical	0.000%	See Attachment	2.91	6.50	Salary	4,915	21-7	3
4	Lynn Ethell	Relative	Clerical	0.000%	See Attachment	1.94	6.50	Salary	3,201	21-7	4
5	Michael Gianni	Relative	Administrative	0.000%	See Attachment	2.26	6.50	Salary	10,997	17-7	5
6	Nina Guzman	Relative	Dietary	0.000%	See Attachment	3.23	6.50	Salary	6,442	1-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 34,555		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 Oakton Pavillion # 0052910 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Generations Oakton Pavillion

0052910

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	Maintenance	Patient Days	693,985	14	\$ 177,702	\$ 95,737	44,893	\$ 11,495	1
2	7	EMP. BEN.-GEN. SERV.	Patient Days	693,985	14	16,617		44,893	1,075	2
3	9	Medical Director	Patient Days	693,985	14	82,000		44,893	5,304	3
4	10	Nursing	Patient Days	693,985	14	589,441	589,441	44,893	38,130	4
5	15	Emp. Ben. - Health Care	Patient Days	693,985	14	73,484		44,893	4,754	5
6	17	Administrative	Patient Days	693,985	14	339,126	339,126	44,893	21,938	6
7	19	Professional Fees	Patient Days	693,985	14	21,409		44,893	1,385	7
8	20	Dues, Fees, and Subscriptions	Patient Days	693,985	14	3,801		44,893	246	8
9	21	Office and Clerical	Patient Days	693,985	14	1,843,191	1,656,700	44,893	119,234	9
10	24	Education and Seminar	Patient Days	693,985	14	2,295		44,893	148	10
11	25	Other Admin. Staff Transp.	Patient Days	693,985	14	140,164		44,893	9,067	11
12	26	Insurance	Patient Days	693,985	14	23,394		44,893	1,513	12
13	27	Emp. Ben. - Gen. Admin.	Patient Days	693,985	14	182,645		44,893	11,815	13
14	32	Interest	Patient Days	693,985	14	(56,845)		44,893	(3,677)	14
15	35	Rental - Auto	Patient Days	693,985	14	51,827		44,893	3,353	15
16	35	Rental - Equipment	Patient Days	693,985	14	11,377		44,893	736	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		\$ 226,516	25

Facility Name & ID Number Generations Oakton Pavillion

0052910

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Patient Days	693,985	14	\$ 99,579	\$ 99,579	44,893	\$ 6,442	1
2	7	Emp. Ben. - Gen. Services	Patient Days	693,985	14	17,250		44,893	1,116	2
3	10	Nursing	Patient Days	693,985	14	107,435	10,745	44,893	6,950	3
4	15	Emp. Ben. - Health Care	Patient Days	693,985	14	18,544		44,893	1,200	4
5	17	Administration	Patient Days	693,985	14	1,421,258	1,421,258	44,893	91,939	5
6	19	Professional Fees	Patient Days	693,985	14	200,000		44,893	12,938	6
7	27	Emp. Ben. - Gen. Admin.	Patient Days	693,985	14	350,079		44,893	22,646	7
8										8
9	10A	Rehab	Special Rehab	329,142	14	179,343	179,343	19,188	10,455	9
10	15	Emp. Ben. - Health Care	Special Rehab	329,142	14	31,236		19,188	1,821	10
11										11
12	6	Maintenance	Maintenance	366,497	14	376,026	376,026	58,968	60,501	12
13	7	Emp. Ben. - Gen. Services	Maintenance	366,497	14	68,296		58,968	10,989	13
14										14
15	5	Utilities	Alloc. Square Feet	12,877	14	25,758		833	1,666	15
16	6	Maintenance	Alloc. Square Feet	12,877	14	16,130		833	1,043	16
17	19	Professional Fees	Alloc. Square Feet	12,877	14	1,139		833	74	17
18	21	Office and Clerical	Alloc. Square Feet	12,877	14	2,063		833	133	18
19	26	Insurance	Alloc. Square Feet	12,877	14	2,682		833	173	19
20	30	Depreciation	Alloc. Square Feet	12,877	14	90,892		833	5,880	20
21	32	Interst	Alloc. Square Feet	12,877	14	75,767		833	4,901	21
22	33	Real Estate Taxes	Alloc. Square Feet	12,877	14	113,223		833	7,324	22
23										23
24										24
25	TOTALS					\$ 3,196,700	\$ 2,086,951		\$ 248,191	25

Facility Name & ID Number Generations Oakton Pavillion

0052910

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation		\$	\$		\$ 1,561	1
2	3	Housekeeping	Direct Allocation					42,436	2
3	4	Laundry	Direct Allocation					700	3
4	6	Maintenance	Direct Allocation					2,302	4
5	10	Nursing	Direct Allocation					117,522	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				\$	\$		\$ 164,817	25

Facility Name & ID Number Generations Oakton Pavillion

0052910

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	Nursing	Direct Allocation		\$	\$		\$ 51,851	1
2	21	Office and Clerical	Direct Allocation					954	2
3	22	Employee Benefits	Direct Allocation						3
4	39	Ancillary	Direct Allocation					103,243	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				\$	\$		\$ 156,048	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Lake Forest Bank & Trust		X	Mortgage		09/02/14	\$ 15,000,000	\$ 17,731,356	09/02/18	4.2000%	\$ 816,566	1								
2	Oakton Pavilion, Inc.	X		Mortgage		09/02/14	2,400,000	2,400,000		4.0000%	120,000	2								
3	Lake Forest Bank & Trust		X	Notes Payable				100,000			8,643	3								
4	1st Source		X	Notes Payable - Vehicle				50,687			3,132	4								
5												5								
Working Capital																				
6	Lake Forest Bank & Trust		X	Line of Credit				700,000			15,752	6								
7	Member	X									40,000	7								
8												8								
9	TOTAL Facility Related						\$ 17,400,000	\$ 20,982,043			\$ 1,004,093	9								
B. Non-Facility Related*																				
10	Alloc. - SIR / Generations	X									1,225	10								
11												11								
12												12								
13	Interest Income										(5,264)	13								
14	TOTAL Non-Facility Related						\$	\$			\$ (4,039)	14								
15	TOTALS (line 9+line14)						\$ 17,400,000	\$ 20,982,043			\$ 1,000,054	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.)

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2016 report.		\$	489,000	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.)		\$	492,800	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3,800	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	396,725	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.		\$	400,525	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2012	<u>383,121</u>	<u>8</u>	
	2013	<u>444,478</u>	<u>9</u>	
	2014	<u>455,827</u>	<u>10</u>	
	2015	<u>465,645</u>	<u>11</u>	
	2016	<u>492,800</u>	<u>12</u>	
Alloc. SIR Management = \$7,324				

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2016	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Generations Oakton Pavillion COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0052910

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)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>09-29-106-006-000</u>	<u>Long Term Care Facility</u>	\$ <u>492,800.00</u>	\$ <u>492,800.00</u>
2. <u>Alloc. - SIR / Generations</u>	<u>Long Term Care Facility</u>	\$ <u>102,606.43</u>	\$ <u>6,637.51</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>595,406.43</u></u>	\$ <u><u>499,437.51</u></u>

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 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 Oakton Pavillion

0052910

Report Period Beginning:

01/01/17

Ending:

12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 92,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

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

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

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

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

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

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

Blank lines for listing other business entities.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Facility, 74,998, 1975, \$ 200,000, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 74,998, (blank), \$ 200,000, 3.

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	294	1980	1980	\$ 4,171,968	\$		\$	\$	4
5									5
6									6
7									7
8									8
Improvement Type**									
9	Various		1981	955					9
10	Various		1983	30,266					10
11	Various		1985	10,972					11
12	Various		1986	6,905					12
13	Various		1987	24,076					13
14	Various		1988	12,905					14
15	Various		1989	7,282					15
16	Various		1990	3,609					16
17	Various		1991	41,760					17
18	Various		1992	4,590					18
19	Various		2001	277,723					19
20	Various		2003	18,438					20
21	Various		2004	41,892					21
22	Various		2005	122,248					22
23	Various		2006	11,911					23
24	Various		2006	244,384					24
25	Various		2007	46,834					25
26	Various		2009	19,153					26
27	Various		2010	73,193					27
28	Various		2011	1,659,265					28
29	Various		2012	52,263					29
30	Carpentry, Tiling, Ceiling, Plumbing, Electrical Work - 1-3 Flrs		2013						30
31	Generator Diesel Reserve Tank		2013	12,740					31
32	Valve For Heat Handler System		2013	6,729					32
33	Wander System for Dementia Parier		2013	9,481					33
34	Circuit Breaker for Electrical Room		2013	5,675					34
35	Fire Alarm System		2013	118,703					35
36	Tubes for Boilers		2013	20,852					36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Generations Oakton Pavillion

0052910

Report Period Beginning:

01/01/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Metal Roof in Ramp Area	2013	\$ 1,393	\$		\$	\$	\$	37
38	Miracle Plumbing - Recirculating Pump	2013	3,700						38
39	Albright - Rebuild Sewer	2014	3,510						39
40	Edwards Engineering - Evaporator Coil	2014	3,575						40
41	Edwards Engineering - Walk In Cooler Compressor	2014	3,450						41
42	Grainger - Sewer and Effluent Pumps	2014	3,477						42
43	Holland Electric - Magnetic Egress Locks / Keypads (Ext Doors)	2014	10,998						43
44	Lionheart Critical Power - Automatic Transfer Switches	2014	10,857						44
45	Pegasus Custom Furniture - Custom Cabinets (Hallways)	2014	3,700						45
46	Snapse Networks - Wireless System Installation	2014	15,425						46
47	Holland Electric - Nurse Call System (1st Floor)	2015	10,870						47
48	Julio Vargas Installation - Irrigation System	2015	5,250						48
49	North Shore Gardens - Landscaping	2015	45,791						49
50	John William Interiors - Carpeting (Room 205 and 218)	2015	3,917						50
51	Holland Electric / MBS - Security System and Cameras	2015	4,576						51
52	Nova Fire Protection - FD Connection Check Valve Repair	2015	4,349						52
53	Pegasus Custom Furniture - Custom Cabinets (Hallways)	2015	6,000						53
54	Sherwin Williams - Room Painting (Capitalized R & M)	2015	3,630						54
55	Hayes Mechanical - Boiler Installation	2016	4,496						55
56	Fox Valley Fire - Backflow Assembly / Kitchen Steamer	2016	6,998						56
57	John William Interiors - Window Treatments	2016	2,587						57
58	Edmonds, Inc. - Exterior and Rooftop Signage	2016	18,501						58
59	Edmonds, Inc. - Exterior and Rooftop Signage ***	2016	1,729						59
60	Rapco - Parking Lot Asphalt Work	2016	9,450						60
61	Digangi Plumbing - Hot Water Heater ***	2016	17,150						61
62	Miracle Plumbing - Replace Kitchen Pipes ***	2016	5,700						62
63	Fox Valley Fire - Backflow Assembly ***	2016	7,275						63
64	Holland Electric - Replace Electrical Panels	2017	11,800						64
65	Jose Roque Inc - Replace Kitchen Cast Iron Pipe	2017	7,500						65
66	J Pegasus Custom - Cabinetry & Counter Tops	2017	4,900						66
67	Jose Roque Inc - Additional Kitchen Cast Iron Pipe Work	2017	7,500						67
68	Edwards Engineering - Replace HVAC Blower Motor	2017	6,655						68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,313,481	\$		\$	\$	\$	70

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 7,313,481	\$		\$	\$	\$		1
2	Generations Health Care Property of Des Plaines, LLC								2
3	Fine Line - Exterior Tuckpointing	2015 71,300							3
4	HD Supply - Panic Hardware on Stairwells	2015 26,966							4
5	Landmark Construction - 1st Floor Renovation Project	2016 1,184,390							5
6	Legat Architects - 1st Floor Renovation Project	2016 111,006							6
7	John Williams Interiors - Window Treatments (Roller Shades)	2016 5,870							7
8	Prints Unlimited - Art Wallwork	2016 5,969							8
9	Prints Unlimited - Art Wallwork ***	2016 3,203							9
10	John Williams Interiors - Window Treatments (Roller Shades)	2016 3,245							10
11	Pegasus Custom Furniture- Therapy Room Built in Cabinets **	2016 6,000							11
12	Pegasus Custom Furniture- Resident Room Built in Cabinets **	2016 54,730							12
13	Holland Electric - Wiring Outlets ***	2016 8,602							13
14	Legat Architects - 1st Floor Renovation Project ***	2016 (45,243)							14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 8,749,519	\$		\$	\$	\$		34

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

Facility Name & ID Number Generations Oakton Pavillion

0052910

Report Period Beginning:

01/01/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 8,749,519	\$		\$	\$	\$	1
2									2
3	SIR Mgmt / Generations HC Network, LLC								3
4									4
5	Various	1993	7,994						5
6	Various	1994	25						6
7	Various	1995	183						7
8	Various	1997	12,283						8
9	Various	1999	966						9
10	Various	1999							10
11	Various	2000	1,140						11
12	Various	2007	3,664						12
13	Various	2008	10,097						13
14	Various	2009	25,090						14
15	Various	2009	34,827						15
16	Various	2011	621						16
17	Various	2012	1,986						17
18	Various	2014	279						18
19	Various	2016	362						19
20									20
21	SIR Mgmt / Generations HC Network, LLC								21
22									22
23	Various	1993	31,530						23
24	Various	1993	511						24
25	Various	1994	300						25
26	Various	1997	119						26
27	Various	1998	1,909						27
28	Various	1999	3,995						28
29	Various	2002	125						29
30	Various	2007	552						30
31	Various	2009	1,893						31
32	Various	2010	1,903						32
33	Various	2012	1,931						33
34	TOTAL (lines 1 thru 33)		\$ 8,893,804	\$		\$	\$	\$	34

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

Facility Name & ID Number Generations Oakton Pavillion

0052910

Report Period Beginning:

01/01/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 8,893,804	\$		\$	\$	\$	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			31,619		31,619		66,739	30
31			755,971		755,971		2,449,040	31
32			9,517		9,517		122,275	32
33								33
34		\$ 8,893,804	\$ 797,107		\$ 797,107	\$	\$ 2,638,054	34

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

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	\$ 382,087	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Alloc - SIR / Generations							74
75	TOTALS	\$ 382,087	\$	\$	\$		\$	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	16 Ford Transit Bus	2016	\$ 61,897	\$	\$	\$		\$	76
77	Alloc. - SIR / Generations									77
78										78
79										79
80	TOTALS			\$ 61,897	\$	\$	\$		\$	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)	\$ 9,537,788	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 797,107	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 797,107	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)	\$ 2,638,054	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.

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

10. Effective dates of current rental agreement:

Beginning _____
 Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2018</u>	\$ _____
13.	<u>/2019</u>	\$ _____
14.	<u>/2020</u>	\$ _____

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

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

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

15. Is Movable equipment rental included in building rental? YES NO
16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Alloc -SIR/Generations</u>		\$	<u>3,353</u>	17
18					18
19					19
20					20
21	TOTAL		\$	3,353	21

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	V10A	hrs	\$ 0	0	\$ 205,173	\$ 0		\$ 205,173	1
2	Licensed Speech and Language Development Therapist	V10A	hrs	0	0	71,222	0		71,222	2
3	Licensed Recreational Therapist	V10A	hrs	0	0	0	0			3
4	Licensed Physical Therapist	V10A	hrs	0	0	243,432	0		243,432	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	V39	##### hrs	133,498	0	0	0	6,937	133,498	8
9	Pharmacy	V39	# of prescrpts	0	0	0	119,628		119,628	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>LAB/RADIOLOGY</u>	V39		0	0	0	17,601		17,601	12
13	Other (specify): <u>BILLABLE SUPPLIES</u>	V39		0	0	0	82,343		82,343	13
14	TOTAL			\$ 133,498		\$ 519,827	\$ 219,572	6,937	\$ 872,897	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 52,437	\$ 354,572	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,207,850	1,207,850	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	148,532	148,532	6
7	Other Prepaid Expenses	6,056	6,056	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	267,677	267,677	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,682,552	\$ 1,984,687	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		700,000	13
14	Buildings, at Historical Cost		15,899,064	14
15	Leasehold Improvements, at Historical Cost	226,318	1,867,546	15
16	Equipment, at Historical Cost	225,968	3,274,149	16
17	Accumulated Depreciation (book methods)	(66,739)	(2,515,781)	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):	1,510,972	4,918,710	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,896,519	\$ 24,143,688	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,579,071	\$ 26,128,375	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 228,698	\$ 228,698	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,000	20,000	28
29	Short-Term Notes Payable	902,154	902,154	29
30	Accrued Salaries Payable	1,347,082	1,347,082	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,804	16,804	31
32	Accrued Real Estate Taxes(Sch.IX-B)		396,725	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	41,804	41,804	35
	Other Current Liabilities(specify):			
36				36
37		97,804	5,443,752	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,654,346	\$ 8,397,019	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		17,731,356	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43		3,000		43
44		229,543		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 232,543	\$ 17,731,356	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,886,889	\$ 26,128,375	46
47	TOTAL EQUITY(page 18, line 24)	\$ 692,182	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,579,071	\$ 26,128,375	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,641,717	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,641,717	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(949,535)	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)	\$ (949,535)	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)	\$ 692,182	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,371,475	1
2	Discounts and Allowances for all Levels	(1,508,519)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,862,956	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,025,051	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,025,051	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	122,242	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,894	19
20	Radiology and X-Ray	370	20
21	Other Medical Services	2,413	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 140,919	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	<u>AL/IL</u>		28
28a	<u>Misc Revenue</u>		28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,028,926	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,549,184	31
32	Health Care	4,118,325	32
33	General Administration	2,403,436	33
B. Capital Expense			
34	Ownership	2,144,504	34
C. Ancillary Expense			
35	Special Cost Centers	362,365	35
36	Provider Participation Fee	400,647	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,978,461	40
41	Income before Income Taxes (line 30 minus line 40)**	(949,535)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (949,535)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,700,146	44
45	Private Pay - Net Inpatient Revenue	1,547,362	45
46	Medicare - Net Inpatient Revenue	1,841,417	46
47	Other-(specify) <u>ALL OTHER SNF/SCF IP REVENUE</u>	4,282,550	47
48	Other-(specify) <u>C/A ANCILLARY ACCOUNTS</u>	(1,508,519)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,862,956	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.

Facility Name & ID Number **Generations Oakton Pavillion**

0052910

Report Period Beginning:

01/01/17

Ending:

12/31/17

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,921	2,086	\$ 95,847	\$ 45.95	1
2	Assistant Director of Nursing	1,338	1,481	54,933	37.09	2
3	Registered Nurses	27,923	30,326	908,560	29.96	3
4	Licensed Practical Nurses	21,412	22,927	599,573	26.15	4
5	CNAs & Orderlies	80,581	85,259	1,097,667	12.87	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	6,584	6,937	133,498	19.24	8
9	Activity Director	0	0	0		9
10	Activity Assistants	15,234	16,103	180,599	11.22	10
11	Social Service Workers	2,942	3,288	46,896	14.26	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	25,636	27,156	345,891	12.74	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	6,113	6,668	96,036	14.40	17
18	Housekeepers	17,875	19,076	201,163	10.55	18
19	Laundry	10,603	10,875	110,096	10.12	19
20	Administrator	1,869	2,086	104,217	49.96	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	12,541	13,399	245,147	18.30	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	5,517	6,161	176,048	28.57	31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify)	2,077	2,219	40,596	18.29	33
34	TOTAL (lines 1 - 33)	240,166	256,047	\$ 4,436,767 *	\$ 17.33	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 9,344	01 - 03	35
36	Medical Director	35,754	09 - 03	36
37	Medical Records Consultant	2,563	10 - 03	37
38	Nurse Consultant			38
39	Pharmacist Consultant	8,968	10 - 03	39
40	Physical Therapy Consultant	548	10A - 03	40
41	Occupational Therapy Consultant	744	10A - 03	41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	88	10A - 03	43
44	Activity Consultant	2,640	11 - 03	44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 60,649		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 63,552	10 - 03	50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides	178,833	10 - 03	52
53	TOTAL (lines 50 - 52)	\$ 242,385		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Burton Barrish	Administrator	10.00%	\$ 104,217	Workers' Compensation Insurance	\$ 58,890	IDPH License Fee	\$	
				Unemployment Compensation Insurance	58,351	Advertising: Employee Recruitment	6,566	
				FICA Taxes	329,480	Health Care Worker Background Check (Indicate # of checks performed)		
				Employee Health Insurance	67,419	Patient Background Checks		
				Employee Meals		Dues and Subscriptions	5,063	
				Illinois Municipal Retirement Fund (IMRF)*		Licenses and Permits	7,210	
				401K Matching Contributions	3,600	Advertising and Promotion	16,519	
				Life Insurance	(3,443)	Alloc. - SIR Mgmt / Generations HCN		
				Other Employee Benefits	15,781			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 35,358	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)					\$ 530,078			
				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
B. Administrative - Other				Description	Line #	Amount	Description	Amount
Description							Out-of-State Travel	\$
Amount								
							In-State Travel	
							Travel	4,873
							Seminar Expense	
							Alloc. - SIR Mgmt / Generations HCN	148
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (For legal fee disclosure, see page 39 of instructions)				TOTAL		\$	TOTAL	\$ 5,021

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Generations Oakton Pavillion

0052910

Report Period Beginning:

01/01/17

Ending:

12/31/17

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. N/A No
- (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?
What was the average life used for new equipment added during this period? Yes
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. \$ 52,775 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?
If YES, give effective date of lease. N/A No
- (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. \$ 400,647
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? Ln 14
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?
Indicate the amount of income earned from providing such transportation during this reporting period.** \$ N/A No
- (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

Item	Quantity	Unit	Price	Total
1.000	1.000	kg	1.000	1.000
2.000	2.000	kg	2.000	2.000
3.000	3.000	kg	3.000	3.000
4.000	4.000	kg	4.000	4.000
5.000	5.000	kg	5.000	5.000
6.000	6.000	kg	6.000	6.000
7.000	7.000	kg	7.000	7.000
8.000	8.000	kg	8.000	8.000
9.000	9.000	kg	9.000	9.000
10.000	10.000	kg	10.000	10.000
11.000	11.000	kg	11.000	11.000
12.000	12.000	kg	12.000	12.000
13.000	13.000	kg	13.000	13.000
14.000	14.000	kg	14.000	14.000
15.000	15.000	kg	15.000	15.000
16.000	16.000	kg	16.000	16.000
17.000	17.000	kg	17.000	17.000
18.000	18.000	kg	18.000	18.000
19.000	19.000	kg	19.000	19.000
20.000	20.000	kg	20.000	20.000
21.000	21.000	kg	21.000	21.000
22.000	22.000	kg	22.000	22.000
23.000	23.000	kg	23.000	23.000
24.000	24.000	kg	24.000	24.000
25.000	25.000	kg	25.000	25.000
26.000	26.000	kg	26.000	26.000
27.000	27.000	kg	27.000	27.000
28.000	28.000	kg	28.000	28.000
29.000	29.000	kg	29.000	29.000
30.000	30.000	kg	30.000	30.000
31.000	31.000	kg	31.000	31.000
32.000	32.000	kg	32.000	32.000
33.000	33.000	kg	33.000	33.000
34.000	34.000	kg	34.000	34.000
35.000	35.000	kg	35.000	35.000
36.000	36.000	kg	36.000	36.000
37.000	37.000	kg	37.000	37.000
38.000	38.000	kg	38.000	38.000
39.000	39.000	kg	39.000	39.000
40.000	40.000	kg	40.000	40.000
41.000	41.000	kg	41.000	41.000
42.000	42.000	kg	42.000	42.000
43.000	43.000	kg	43.000	43.000
44.000	44.000	kg	44.000	44.000
45.000	45.000	kg	45.000	45.000
46.000	46.000	kg	46.000	46.000
47.000	47.000	kg	47.000	47.000
48.000	48.000	kg	48.000	48.000
49.000	49.000	kg	49.000	49.000
50.000	50.000	kg	50.000	50.000
51.000	51.000	kg	51.000	51.000
52.000	52.000	kg	52.000	52.000
53.000	53.000	kg	53.000	53.000
54.000	54.000	kg	54.000	54.000
55.000	55.000	kg	55.000	55.000
56.000	56.000	kg	56.000	56.000
57.000	57.000	kg	57.000	57.000
58.000	58.000	kg	58.000	58.000
59.000	59.000	kg	59.000	59.000
60.000	60.000	kg	60.000	60.000
61.000	61.000	kg	61.000	61.000
62.000	62.000	kg	62.000	62.000
63.000	63.000	kg	63.000	63.000
64.000	64.000	kg	64.000	64.000
65.000	65.000	kg	65.000	65.000
66.000	66.000	kg	66.000	66.000
67.000	67.000	kg	67.000	67.000
68.000	68.000	kg	68.000	68.000
69.000	69.000	kg	69.000	69.000
70.000	70.000	kg	70.000	70.000
71.000	71.000	kg	71.000	71.000
72.000	72.000	kg	72.000	72.000
73.000	73.000	kg	73.000	73.000
74.000	74.000	kg	74.000	74.000
75.000	75.000	kg	75.000	75.000
76.000	76.000	kg	76.000	76.000
77.000	77.000	kg	77.000	77.000
78.000	78.000	kg	78.000	78.000
79.000	79.000	kg	79.000	79.000
80.000	80.000	kg	80.000	80.000
81.000	81.000	kg	81.000	81.000
82.000	82.000	kg	82.000	82.000
83.000	83.000	kg	83.000	83.000
84.000	84.000	kg	84.000	84.000
85.000	85.000	kg	85.000	85.000
86.000	86.000	kg	86.000	86.000
87.000	87.000	kg	87.000	87.000
88.000	88.000	kg	88.000	88.000
89.000	89.000	kg	89.000	89.000
90.000	90.000	kg	90.000	90.000
91.000	91.000	kg	91.000	91.000
92.000	92.000	kg	92.000	92.000
93.000	93.000	kg	93.000	93.000
94.000	94.000	kg	94.000	94.000
95.000	95.000	kg	95.000	95.000
96.000	96.000	kg	96.000	96.000
97.000	97.000	kg	97.000	97.000
98.000	98.000	kg	98.000	98.000
99.000	99.000	kg	99.000	99.000
100.000	100.000	kg	100.000	100.000

