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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0054858

Facility Name: Generations at Lincoln, LLC

Address: 2202 N Kickapoo Street (Number) Lincoln (City) 6265 (Zip Code)

County: Logan

Telephone Number: (217) 735-1538 **Fax #** (217) 732-4818

HFS ID Number:

Date of Initial License for Current Owners:

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: Denise A. Gadomski, CPA **Telephone Number:** (216) 274-6514
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 01/01/18 to 12/31/18 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) Denise A. Gadomski, CPA, Partner
(Firm Name & Address) Plante & Moran, PLLC, 200 N Martingale Road, Suite 900, Shaumburg, IL 60173
(Telephone) (216) 274-6514 Fax # (248) 233-7349

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Generations at Lincoln, LLC # 0054858 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	Skilled (SNF)	101	36,865	1
2		Skilled Pediatric (SNF/PED)			2
3	25	Intermediate (ICF)	25	9,125	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	126	TOTALS	126	45,990	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	3,034	267	4,367	7,668	8
9	SNF/PED					9
10	ICF	16,241	1,903	3,014	21,158	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,275	2,170	7,381	28,826	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.68%

D. How many bed reserve days during this year were paid by the Department?
N/A (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 01/01/2018

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/2018 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 99 and days of care provided 2,665

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: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Generations at Lincoln, LLC # 0054858 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	198,539	25,266	14,881	238,686		238,686	(6,155)	232,531			1
2	Food Purchase		205,483		205,483		205,483		205,483			2
3	Housekeeping	190,622		26,935	217,557		217,557	(1,429)	216,128			3
4	Laundry	37,419		20,642	58,061		58,061	(300)	57,761			4
5	Heat and Other Utilities			190,077	190,077		190,077	1,045	191,122			5
6	Maintenance	32,911	80,400		113,311		113,311	(1,923)	111,388			6
7	Other (specify):*			5,002	5,002		5,002	1,944	6,946			7
8	TOTAL General Services	459,491	311,149	257,537	1,028,177		1,028,177	(6,818)	1,021,359			8
	B. Health Care and Programs											
9	Medical Director			114,850	114,850		114,850		114,850			9
10	Nursing and Medical Records	2,009,292	253,879	48,495	2,311,666		2,311,666	(18,983)	2,292,683			10
10a	Therapy			590,040	590,040		590,040	(4,885)	585,155			10a
11	Activities	57,278		6,905	64,183		64,183		64,183			11
12	Social Services	37,209		2,697	39,906		39,906		39,906			12
13	CNA Training											13
14	Program Transportation			1,731	1,731		1,731		1,731			14
15	Other (specify):*							4,221	4,221			15
16	TOTAL Health Care and Programs	2,103,779	253,879	764,718	3,122,376		3,122,376	(19,647)	3,102,729			16
	C. General Administration											
17	Administrative	114,830			114,830		114,830	4,096	118,926			17
18	Directors Fees											18
19	Professional Services			370,493	370,493		370,493	(183,977)	186,516			19
20	Dues, Fees, Subscriptions & Promotions			3,599	3,599		3,599	56	3,655			20
21	Clerical & General Office Expenses	192,638	42,975	99,802	335,415		335,415	(26,825)	308,590			21
22	Employee Benefits & Payroll Taxes			424,670	424,670		424,670	(116)	424,554			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,664	10,664		10,664	140	10,804			24
25	Other Admin. Staff Transportation							8,931	8,931			25
26	Insurance-Prop.Liab.Malpractice			129,665	129,665		129,665	908	130,573			26
27	Other (specify):*			47,317	47,317		47,317	1,333	48,650			27
28	TOTAL General Administration	307,468	42,975	1,086,210	1,436,653		1,436,653	(195,454)	1,241,199			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,870,738	608,003	2,108,465	5,587,206		5,587,206	(221,919)	5,365,287			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 Lincoln, LLC
Medicaid Cost Report
01/01/18 - 12/31/18

Page 3 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 7 - Other General Services				
Trash and Refuse Removal			5,002	5,002
Alloc. - Generations HCN			1,944	1,944
Employee Benefits				-
				-
				-
				-
				-
Sub-Total	-	-	6,946	6,946
Line 15 - Other Health Care Services				
Alloc. - Generations HCN			4,221	4,221
Employee Benefits				-
				-
				-
				-
				-
				-
Sub-Total	-	-	4,221	4,221
Line 27 - Other General Administration				
Other Administrative			47,317	47,317
				-
				-
Alloc. - Generations HCN			1,333	1,333
Employee Benefits				-
				-
				-
Sub-Total	-	-	48,650	48,650

Facility Name & ID Number Generations at Lincoln, LLC #0054858 Report Period Beginning: 01/01/18 Ending: 12/31/18

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			3,119	3,119		3,119	124,625	127,744			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			57,452	57,452		57,452	93,025	150,477			32
33	Real Estate Taxes			74,701	74,701		74,701	8,416	83,117			33
34	Rent-Facility & Grounds			192,000	192,000		192,000	(192,000)				34
35	Rent-Equipment & Vehicles			70,548	70,548		70,548	2,108	72,656			35
36	Other (specify):*			432	432		432	(432)				36
37	**TOTAL Ownership**			398,252	398,252		398,252	35,742	433,994			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	361,949	94,965	178,428	635,342		635,342	(10,049)	625,293			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			227,782	227,782		227,782		227,782			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	361,949	94,965	406,210	863,124		863,124	(10,049)	853,075			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,232,687	702,968	2,912,927	6,848,582		6,848,582	(196,226)	6,652,356			45

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

Facility Name & ID Number Generations at Lincoln, LLC # 0054858 Report Period Beginning: 01/01/18 Ending: 12/31/18

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(432)	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	(74,588)	21		24
25	Fund Raising, Advertising and Promotional	(17,827)	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	(36,155)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (129,002)		$	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)	(67,224)	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (67,224)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (196,226)		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

Generations at Lincoln, LLC

ID# 0054858

Report Period Beginning: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Independent Living	$ 0	43	1
2	Non-Allowable Benefits (Marketing & ILU)	0	22	2
3	Legal Fees - Collections	(3,232)	19	3
4	Bank Fees	(6,111)	21	4
5		0		5
6		0		6
7		0		7
8		0		8
9		0		9
10		0		10
11		0		11
12	Generations Healthcare Property of Lincoln, LLC	0		12
13	Professional Fees	(15,111)	19	13
14	Dues and Subscriptions	(115)	20	14
15	Amortization	(11,586)	31	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**	(36,155)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Generations at Lincoln, LLC # 0054858 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	(5,862)	0	(293)	0	0	0	0	0	(6,155)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	(1,429)	0	0	0	0	0	(1,429)	3
4	Laundry	0	0	0	0	0	(300)	0	0	0	0	0	(300)	4
5	Heat and Other Utilities	0	0	0	1,045	0	0	0	0	0	0	0	1,045	5
6	Maintenance	0	0	(2,458)	1,406	0	(871)	0	0	0	0	0	(1,923)	6
7	Other (specify):*	0	0	612	1,332	0	0	0	0	0	0	0	1,944	7
8	**TOTAL General Services**	0	0	(1,846)	(2,079)	0	(2,893)	0	0	0	0	0	(6,818)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	(16,878)	3,930	(1,899)	(4,136)	0	0	0	0	0	(18,983)	10
10a	Therapy	0	0	0	(1,762)	0	(3,123)	0	0	0	0	0	(4,885)	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	2,969	1,252	0	0	0	0	0	0	0	4,221	15
16	**TOTAL Health Care and Programs**	0	0	(13,909)	3,420	(1,899)	(7,259)	0	0	0	0	0	(19,647)	16
	C. General Administration													
17	Administrative	0	0	(56,763)	60,859	0	0	0	0	0	0	0	4,096	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(18,343)	14,611	(187,624)	7,379	0	0	0	0	0	0	0	(183,977)	19
20	Fees, Subscriptions & Promotions	(115)	115	56	0	0	0	0	0	0	0	0	56	20
21	Clerical & General Office Expenses	(80,699)	0	53,818	56	0	0	0	0	0	0	0	(26,825)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	(116)	0	0	0	0	0	0	(116)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	140	0	0	0	0	0	0	0	0	140	24
25	Other Admin. Staff Transportation	0	0	8,931	0	0	0	0	0	0	0	0	8,931	25
26	Insurance-Prop.Liab.Malpractice	0	0	779	129	0	0	0	0	0	0	0	908	26
27	Other (specify):*	(17,827)	0	4,915	14,245	0	0	0	0	0	0	0	1,333	27
28	**TOTAL General Administration**	(116,984)	14,726	(175,748)	82,668	(116)	0	0	0	0	0	0	(195,454)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(116,984)	14,726	(191,503)	84,009	(2,015)	(10,152)	0	0	0	0	0	(221,919)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Generations at Lincoln, LLC # 0054858 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	121,815	0	2,810	0	0	0	0	0	0	0	124,625	30
31	Amortization of Pre-Op. & Org.	(11,586)	11,586	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	105,067	(14,589)	2,547	0	0	0	0	0	0	0	93,025	32
33	Real Estate Taxes	0	4,369	0	4,047	0	0	0	0	0	0	0	8,416	33
34	Rent-Facility & Grounds	0	(192,000)	0	0	0	0	0	0	0	0	0	(192,000)	34
35	Rent-Equipment & Vehicles	0	0	2,108	0	0	0	0	0	0	0	0	2,108	35
36	Other (specify):*	(432)	0	0	0	0	0	0	0	0	0	0	(432)	36
37	TOTAL Ownership	(12,018)	50,837	(12,481)	9,404	0	0	0	0	0	0	0	35,742	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	(10,049)	0	0	0	0	0	0	(10,049)	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	(10,049)	0	0	0	0	0	0	(10,049)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(129,002)	65,563	(203,984)	93,413	(12,064)	(10,152)	0	0	0	0	0	(196,226)	45

Facility Name & ID Number Generations at Lincoln, LLC # 0054858 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 192,000	Generations Healthcare Property of Lincoln, LLC		$	$ (192,000)	1
2	V	33	Real Estate Taxes	74,701	Generations Healthcare Property of Lincoln, LLC		79,070	4,369	2
3	V	19	Professional Fees		Generations Healthcare Property of Lincoln, LLC		14,611	14,611	3
4	V	20	Dues and Subscriptions		Generations Healthcare Property of Lincoln, LLC		115	115	4
5	V	30	Depreciation		Generations Healthcare Property of Lincoln, LLC		121,815	121,815	5
6	V	31	Amortization		Generations Healthcare Property of Lincoln, LLC		11,586	11,586	6
7	V	32	Interest		Generations Healthcare Property of Lincoln, LLC		105,067	105,067	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 266,701			$ 332,264	$ * 65,563	14

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

Facility Name & ID Number Generations at Lincoln, LLC # 0054858 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	Atied Associates, LLC	33.3334	Albany Care, Inc.	Cook, IL				1
2	Barrish Group Limited Partnership	24.6333	Generations at Applewood, LLC	Matteson, IL	Generations Prop.	Lincolnwood, IL	Bldg. Company	2
3	Juliana R. Barrish Trust dated 9/1/04	24.6333	Auburn Village	Auburn, IL	Generations HC			3
4	Michael Giannini Trust dated 9/13/00	8.7000	Bryan Mawr Care, Inc.	Chicago, IL	Transitions	Lincolnwood, IL	Mgmt. Company	4
5	Celeste Giannini Trust dated 3/13/00	8.7000	Generations At Columbus Park, Inc.	Chicago, IL	SIR Management	Lincolnwood, IL	Mgmt. Company	5
6			Decatur Manor Healthcare, LLC	Decatur, IL	SIR Properties	Lincolnwood, IL	Bldg. Company	6
7			Generations at Elmwood Park, Inc.	Elmwood Park, IL	Max RX, LLC	Des Plaines, IL	Pharmacy	7
8			Greenwood Care, Inc.	Evanston, IL	LTC Lab, LLC	Lincolnwood, IL	Ancillary Supplies	8
9			Generations at Lincoln, LLC	Lincoln, IL				9
10			Generations at McKinley Court, LLC	Decatur, IL				10
11			Generations at McKinley Place, LLC	Decatur, IL				11
12			Generations at Neighbors, LLC	Byron, IL				12
13			Generations at Oakton Arms, LLC	Des Plaines, IL				13
14			Generations at Oakton Pavillion, LLC	Des Plaines, IL				14
15			Generations at Peoria	Peoria, IL				15
16			Generations at Regency, LLC	Niles, IL				16
17			Generations at Riverview, LLC	East Peoria, IL				17
18			Generations at Riverview Senior Living	East Peoria, IL				18
19			Generations at Rock Island, LLC	Rock Island, IL				19
20			Wilson Care, Inc.	Chicago, IL				20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Generations at Lincoln, LLC # 0054858 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	REPAIRS AND MAINT.	$ 9,324	GENERATIONS HC NETWORK, LLC		$ 6,866	$ (2,458)	15
16	V	7	EMP. BEN.-GEN. SERV.		GENERATIONS HC NETWORK, LLC		612	612	16
17	V	9	MEDICAL DIRECTOR CONSULTS		GENERATIONS HC NETWORK, LLC				17
18	V	10	NURSING	34,632	GENERATIONS HC NETWORK, LLC		17,754	(16,878)	18
19	V	15	EMP. BEN.-H.C.		GENERATIONS HC NETWORK, LLC		2,969	2,969	19
20	V	17	ADMINISTRATIVE	70,596	GENERATIONS HC NETWORK, LLC		13,833	(56,763)	20
21	V	19	PROFESSIONAL FEES	193,140	GENERATIONS HC NETWORK, LLC		5,516	(187,624)	21
22	V	20	FEES, SUBSCRIPTIONS		GENERATIONS HC NETWORK, LLC		56	56	22
23	V	21	CLERICAL & GENERAL	23,976	GENERATIONS HC NETWORK, LLC		77,794	53,818	23
24	V	24	EDUCATION & SEMINAR		GENERATIONS HC NETWORK, LLC		140	140	24
25	V	25	OTHER ADMIN. STAFF TRANS.		GENERATIONS HC NETWORK, LLC		8,931	8,931	25
26	V	26	INSURANCE		GENERATIONS HC NETWORK, LLC		779	779	26
27	V	27	EMP. BEN.-GEN. ADMIN.		GENERATIONS HC NETWORK, LLC		4,915	4,915	27
28	V	32	INTEREST		GENERATIONS HC NETWORK, LLC		(14,589)	(14,589)	28
29	V	35	AUTO RENTAL		GENERATIONS HC NETWORK, LLC		1,700	1,700	29
30	V	35	EQUIPMENT RENTAL		GENERATIONS HC NETWORK, LLC		408	408	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			$ 331,668			$ 127,684	$ * (203,984)	39

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

Facility Name & ID Number Generations at Lincoln, LLC # 0054858 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 SALARIES	$ 9,324	GENERATIONS HC NETWORK, LLC		$ 3,462	$ (5,862)	15
16	V	7	EMP. BEN.-DIETARY		GENERATIONS HC NETWORK, LLC		580	580	16
17	V	10	NURSING SALARIES		GENERATIONS HC NETWORK, LLC		3,930	3,930	17
18	V	15	EMP. BEN.-NURSING		GENERATIONS HC NETWORK, LLC		654	654	18
19	V	17	ADMIN./LEGAL SALARIES		GENERATIONS HC NETWORK, LLC		60,859	60,859	19
20	V	19	FIN. CONSULT./REGL. DIR.		GENERATIONS HC NETWORK, LLC		7,223	7,223	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		GENERATIONS HC NETWORK, LLC		14,245	14,245	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	5,328	GENERATIONS HC NETWORK, LLC		3,566	(1,762)	24
25	V	15	EMPLOYEE BENEFITS		GENERATIONS HC NETWORK, LLC		598	598	25
26	V								26
27	V	6	MAINTENANCE SALARIES	3,456	GENERATIONS HC NETWORK, LLC		4,258	802	27
28	V	7	EMPLOYEE BENEFITS		GENERATIONS HC NETWORK, LLC		752	752	28
29	V								29
30	V	5	UTILITIES		GENERATIONS HC NETWORK, LLC		1,045	1,045	30
31	V	6	REPAIRS AND MANT.		GENERATIONS HC NETWORK, LLC		604	604	31
32	V	19	PROFESSIONAL FEES		GENERATIONS HC NETWORK, LLC		156	156	32
33	V	21	CLERICAL & GENERAL		GENERATIONS HC NETWORK, LLC		56	56	33
34	V	26	INSURANCE		GENERATIONS HC NETWORK, LLC		129	129	34
35	V	30	DEPRECIATION		GENERATIONS HC NETWORK, LLC		2,810	2,810	35
36	V	32	INTEREST		GENERATIONS HC NETWORK, LLC		2,547	2,547	36
37	V	33	REAL ESTATE TAXES		GENERATIONS HC NETWORK, LLC		4,047	4,047	37
38	V								38
39	Total			$ 18,108			$ 111,521	$ * 93,413	39

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

Facility Name & ID Number Generations at Lincoln, LLC # 0054858 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$	MAC Rx, LLC		$	$	15
16	V	10	Nursing and Medical Records	22,027	MAC Rx, LLC		20,128	(1,899)	16
17	V	10A	Therapy		MAC Rx, LLC				17
18	V	19	Professional Services		MAC Rx, LLC				18
19	V	21	Clerical & General Offie Expenses		MAC Rx, LLC				19
20	V	22	Employee Benefits	1,348	MAC Rx, LLC		1,232	(116)	20
21	V	39	Ancillary	116,594	MAC Rx, LLC		106,545	(10,049)	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			$ 139,969			$ 127,905	$ * (12,064)	39

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

Facility Name & ID Number Generations at Lincoln, LLC # 0054858 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 3,052	Big Ten Supply, LLC		$ 2,759	$ (293)	15
16	V	3	Housekeeping	14,930	Big Ten Supply, LLC		13,501	(1,429)	16
17	V	4	Laundry	3,142	Big Ten Supply, LLC		2,842	(300)	17
18	V	6	Repairs & Maintenance	9,101	Big Ten Supply, LLC		8,230	(871)	18
19	V	10	Nursing and Medical Records	43,185	Big Ten Supply, LLC		39,049	(4,136)	19
20	V	10A	Therapy	32,621	Big Ten Supply, LLC		29,498	(3,123)	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 106,031			$ 95,879	$ * (10,152)	39

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

Facility Name & ID Number Generations at Lincoln, LLC # 0054858 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	Elka Abramchick	Relative	Clerical	0.00	See Attachment	1.13	3.54	Salary	$ 1,657	21-7	1
2	Joey Abramchik	Relative	Administrative	0.00	See Attachment	1.42	3.54	Salary	7,223	17-7	2
3	Bryan Barrish	Relative	Administrative	0.00	See Attachment	1.24	3.10	Salary	8,859	17-7	3
4	Sarah Barrish	Relative	Administrative	0.00	See Attachment	1.77	3.54	Salary	4,456	17-7	4
5	Louise Bergthold	Relative	Administrative	0.00	See Attachment	2.13	3.54	Salary	8,859	17-7	5
6	Thomas Bergthold	Relative	Clerical	0.00	See Attachment	1.42	3.54	Salary	1,753	21-7	6
7	Andrew Chin	Relative	Clerical	0.00	See Attachment	1.42	3.54	Salary	2,974	21-7	7
8	Fay Chin	Relative	Nursing	0.00	See Attachment	1.42	3.54	Salary	3,930	10-7	8
9	Clark Collins	Relative	Administrative	0.00	See Attachment	1.5	3.75	Salary	1,875	Var.	9
10	Lynn Ethell	Relative	Clerical	0.00	See Attachment	1.06	3.54	Salary	1,795	21-7	10
11	Michael Giannini	Relative	Administrative	0.00	See Attachment	1.24	3.10	Salary	6,407	17-7	11
12	Nenita Guzman	Relative	Dietary	0.00	See Attachment	1.77	3.54	Salary	3,462	1-7	12
13								TOTAL	$ 53,250		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 Lincoln, LLC # 0054858 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	Jeff Oravec	Relative	Administrative	0.00	See Attachment	1.42	3.54	Salary	$ 4,974	17-7	1
2	Kristen Schloss	Relative	Maintenance	0.00	See Attachment	1.42	3.54	Salary	3,655	6-7	2
3	Kim Shelton	Relative	Clerical	0.00	See Attachment	1.59	3.54	Salary	2,732	21-7	3
4	Thomas Winter	Owner	Administrative	0.00	See Attachment	2.13	3.54	Salary	8,859	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 20,220		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 Lincoln, LLC # 0054858 Report Period Beginning: 01/01/18 Ending: 12/31/18

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: Generations Healthcare Property of Lincoln, 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

Facility Name & ID Number Generations at Lincoln, LLC # 0054858 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	REPAIRS AND MAINT.	PATIENT DAYS	813,429	20	$ 193,743	$ 103,385	28,826	$ 6,866	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	813,429	20	17,260		28,826	612	2
3	9	MEDICAL DIRECTOR CONSUI	PATIENT DAYS	813,429	20			28,826		3
4	10	NURSING	PATIENT DAYS	813,429	20	501,001	501,001	28,826	17,754	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	813,429	20	83,773		28,826	2,969	5
6	17	ADMINISTRATIVE	PATIENT DAYS	813,429	20	390,351	390,351	28,826	13,833	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	813,429	20	155,641		28,826	5,516	7
8	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	813,429	20	1,590		28,826	56	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	813,429	20	2,195,251	1,959,905	28,826	77,795	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	813,429	20	3,956		28,826	140	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	813,429	20	252,011		28,826	8,931	11
12	26	INSURANCE	PATIENT DAYS	813,429	20	21,989		28,826	779	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	813,429	20	138,692		28,826	4,915	13
14	32	INTEREST	PATIENT DAYS	813,429	20	(411,674)		28,826	(14,589)	14
15	35	AUTO RENTAL	PATIENT DAYS	813,429	20	47,983		28,826	1,700	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	813,429	20	11,512		28,826	408	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,603,079	$ 2,954,642		$ 127,685	25

Facility Name & ID Number Generations at Lincoln, LLC # 0054858 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 SALARIES	PATIENT DAYS	813,429	20	$ 97,690	$ 97,690	28,826	$ 3,462	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	813,429	20	16,359		28,826	580	2
3	10	NURSING SALARIES	PATIENT DAYS	813,429	20	110,913	110,913	28,826	3,930	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	813,429	20	18,452		28,826	654	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	813,429	20	1,717,366	1,717,366	28,826	60,859	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	813,429	20	203,820		28,826	7,223	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	813,429	20	401,962		28,826	14,245	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	284,688	14	190,531	190,531	5,328	3,566	10
11	15	EMPLOYEE BENEFITS	SPECIAL REHAB INC.	284,688	14	31,950		5,328	598	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANC INC.	368,277	19	453,836	453,836	3,456	4,259	13
14	7	EMPLOYEE BENEFITS	MAINTENANC INC.	368,277	19	80,131		3,456	752	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	20	29,526		456	1,045	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	20	17,073		456	604	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	20	4,403		456	156	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	20	1,572		456	56	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	20	3,650		456	129	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	20	79,352		456	2,810	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	20	71,924		456	2,547	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	20	114,307		456	4,047	23
24										24
25	TOTALS					$ 3,644,817	$ 2,570,336		$ 111,522	25

Facility Name & ID Number Generations at Lincoln, LLC # 0054858 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	6	Maintenance	Direct Allocation			$	$		$	1
2	10	Nursing and Medical Records	Direct Allocation						20,128	2
3	10A	Therapy	Direct Allocation							3
4	19	Professional Services	Direct Allocation							4
5	21	Clerical & General Office Expense	Direct Allocation							5
6	22	Employee Benefits	Direct Allocation						1,232	6
7	39	Ancillary	Direct Allocation						106,545	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					$	$		$ 127,905	25

Facility Name & ID Number Generations at Lincoln, LLC # 0054858 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation			$	$		$ 2,759	1
2	3	Housekeeping	Direct Allocation						13,501	2
3	4	Laundry	Direct Allocation						2,842	3
4	6	Repairs & Maintenance	Direct Allocation						8,230	4
5	10	Nursing and Medical Records	Direct Allocation						39,049	5
6	10A	Therapy	Direct Allocation						29,498	6
7	21	Clerical & General	Direct Allocation							7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 95,879	25

Facility Name & ID Number Generations at Lincoln, LLC # 0054858 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	Republic Bank		X	Mortgage			$ 2,251,125	$ 2,251,125	7/27/21	5.5000	$ 53,996	1
2	Republic Bank		X	Line of Credit			4,166	4,166	7/27/21	5.2500	55	2
3												3
4												4
5												5
	Working Capital											
6	Shareholder Loans	X		Line of Credit							51,017	6
7												7
8												8
9	TOTAL Facility Related						$ 2,255,291	$ 2,255,291			$ 105,068	9
	B. Non-Facility Related*											
10	Alloc. SIR / Generations	X									45,409	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 45,409	14
15	TOTALS (line 9+line14)						$ 2,255,291	$ 2,255,291			$ 150,477	15

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

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

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

Facility Name & ID Number Generations at Lincoln, LLC # 0054858 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	75,695	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.)	$	83,117	2
3. Under or (over) accrual (line 2 minus line 1).	$	7,422	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	75,695	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.	$	83,117	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	70,799	8
	2014	70,674	9
	2015	73,661	10
	2016	74,211	11
	2017	74,701	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2017	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

Real Estate Tax Accrual = $74,701

Alloc. SIR Management = $3,821

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.**

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Generations at Lincoln, LLC COUNTY Logan

FACILITY IDPH LICENSE NUMBER 0054858

CONTACT PERSON REGARDING THIS REPORT Denise A. Gadomski, CPA

TELEPHONE (216) 274-6514 FAX #: (248) 233-7349

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-029-019-00	Long Term Care Facility	$ 46,366.38	$ 46,366.38
2.	08-029-019-50	Long Term Care Facility	$ 28,334.96	$ 28,334.96
3.	Alloc. - SIR Management	Long Term Care Facility	$ 107,928.00	$ 3,821.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 182,629.34	$ 78,522.34

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Lincoln, LLC # 0054858 Report Period Beginning: 01/01/18 Ending: 12/31/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,852 B. General Construction Type: Exterior Masonry Frame Stee/Wood 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).

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		2018	$ 30,000	1
2					2
3	TOTALS			$ 30,000	3

Facility Name & ID Number Generations at Lincoln, LLC # 0054858 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	126		2018		$ 2,358,000	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Fleshman plumbing - water heaters (2)			2018	23,407						10
11	Fleshman plumbing - water heaters			2018	11,703						11
12	Automatic Fire Sprinkler - replaced head			2018	19,871						12
13	Automatic Fire Sprinkler - replaced air compressor			2018	2,811						13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*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 at Lincoln, LLC # 0054858 Report Period Beginning: 01/01/18 Ending: 12/31/18

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)		$ 2,415,792	$		$	$	$	70

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

Facility Name & ID Number Generations at Lincoln, LLC # 0054858 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 2,415,792	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,415,792	$		$	$	$	34

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

Facility Name & ID Number Generations at Lincoln, LLC # 0054858 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 2,415,792	$		$	$	$	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	FS Depreciation - Generations at Lincoln, LLC			1,847		1,847		1,847	29
30	FS Depreciation - Generations Healthcare Property of Lincoln, LLC			121,815		121,815		121,815	30
31	FS Depreciation - SIR Mgmt / Generations HC Network, LLC			4,166		4,166		82,440	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,415,792	$ 127,828		$ 127,828	$	$ 206,102	34

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

Facility Name & ID Number Generations at Lincoln, LLC # 0054858 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$	$	$	$		$	71
72	Current Year Purchases	16,408						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 16,408	$	$	$		$	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 2,462,200	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 127,828	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 127,828	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)	$ 206,102	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Generations at Lincoln, LLC # 0054858 Report Period Beginning: 01/01/18 Ending: 12/31/18

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								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: $ 408 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. - Generation HCN		$	$ 1,700	17
18					18
19					19
20					20
21	TOTAL		$	$ 1,700	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.

Facility Name & ID Number Generations at Lincoln, LLC # 0054858 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff 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	0.00	hrs	$ 0	3,169	$ 249,678	$ 0	3,169	$ 249,678	1
2	Licensed Speech and Language Development Therapist	V10A	0.00	hrs	0	834	76,745	0	834	76,745	2
3	Licensed Recreational Therapist	V10A	0.00	hrs	0	0	0	0			3
4	Licensed Physical Therapist	V10A	0.00	hrs	0	3,393	258,732	0	3,393	258,732	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation	V39	#####	hrs	351,900	0	0	0	1,828	351,900	8
9	Pharmacy	V39	0.00	# of prescrpts	0	0	0	170,798		170,798	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): LAB/RADIOLOGY	V39	0.00		0	0	0	7,630		7,630	12
13	Other (specify): BILLABLE SUPPLIES	V39	0.00		0	0	0	94,965		94,965	13
14	TOTAL				$ 351,900	7,396	$ 585,155	$ 273,393	9,224	$ 1,210,448	14

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

Facility Name & ID Number Generations at Lincoln, LLC # 0054858 Report Period Beginning: 01/01/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/18 (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	$ 69,862	$ 214,833	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,632,985	2,632,985	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(17,885)	(17,885)	6
7	Other Prepaid Expenses	4,994	4,994	7
8	Accounts Receivable (owners or related parties)		380,000	8
9	Other(specify):	(103,427)	(103,427)	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,586,529	$ 3,111,500	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		30,000	13
14	Buildings, at Historical Cost		2,328,000	14
15	Leasehold Improvements, at Historical Cost	57,792	57,792	15
16	Equipment, at Historical Cost	16,408	661,173	16
17	Accumulated Depreciation (book methods)	(3,119)	(124,934)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		31,833	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(6,367)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	358,175	415,656	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 429,256	$ 3,393,153	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,015,785	$ 6,504,653	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 334,643	$ 334,646	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,700,000	2,058,175	29
30	Accrued Salaries Payable	294,469	294,469	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,691	13,691	31
32	Accrued Real Estate Taxes(Sch.IX-B)		86,000	32
33	Accrued Interest Payable		8,958	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	13,421	13,421	35
	Other Current Liabilities(specify):			
36				36
37	Other Liabilities	291,894	291,894	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,648,118	$ 3,101,254	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		4,166	39
40	Mortgage Payable		2,251,125	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Related Party Loans	2,848	2,848	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,848	$ 2,258,139	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,650,966	$ 5,359,393	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 364,820	$ 1,145,260	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,015,786	$ 6,504,653	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	76,711	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) **Partner Capital**	298,410	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 375,121	17
	B. Transfers (Itemize):		
18	**ILU net asset activity for the year**	(10,301)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (10,301)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 364,820	24 *

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,901,611	1
2	Discounts and Allowances for all Levels	(1,328,847)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,572,764	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,148,468	6
7	Oxygen	19,280	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,167,748	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	141,814	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,823	19
20	Radiology and X-Ray	2,759	20
21	Other Medical Services	35,385	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 184,781	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		28
28a	Misc Revenue		28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,925,293	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,028,177	31
32	Health Care	3,122,376	32
33	General Administration	1,436,653	33
	B. Capital Expense		
34	Ownership	398,252	34
	C. Ancillary Expense		
35	Special Cost Centers	635,342	35
36	Provider Participation Fee	227,782	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,848,582	40
41	**Income before Income Taxes (line 30 minus line 40)****	76,711	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 76,711	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,137,947	44
45	Private Pay - Net Inpatient Revenue	430,920	45
46	Medicare - Net Inpatient Revenue	1,332,500	46
47	Other-(specify) ALL OTHER SNF/SCF IP REVENUE	1,000,244	47
48	Other-(specify) C/A ANCILLARY ACCOUNTS	(1,328,847)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,572,764	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.**

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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	1,987	2,146	$ 85,615	$ 39.90	1
2	Assistant Director of Nursing	1,566	1,748	50,111	28.67	2
3	Registered Nurses	8,292	8,710	304,417	34.95	3
4	Licensed Practical Nurses	22,374	24,255	640,566	26.41	4
5	CNAs & Orderlies	53,677	56,161	844,034	15.03	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	9,250	10,074	283,360	28.13	7
8	Rehab/Therapy Aides	1,656	1,828	78,590	42.99	8
9	Activity Director	0	0	0		9
10	Activity Assistants	4,202	4,324	57,278	13.25	10
11	Social Service Workers	1,978	2,091	37,209	17.79	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	17,009	18,204	198,539	10.91	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	1,440	1,548	32,911	21.26	17
18	Housekeepers	16,373	17,308	190,622	11.01	18
19	Laundry	4,106	4,276	37,419	8.75	19
20	Administrator	2,300	2,417	114,830	47.51	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	8,698	9,490	192,638	20.30	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	2,326	2,531	84,549	33.41	31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	157,234	167,111	$ 3,232,688 *	$ 19.34	34

* 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	0	$ 14,881	V01-3	35
36	Medical Director	0	114,850	V09-3	36
37	Medical Records Consultant	0	0		37
38	Nurse Consultant	0	0		38
39	Pharmacist Consultant	0	6,602	V10-3	39
40	Physical Therapy Consultant	0	28,371	V10A-3	40
41	Occupational Therapy Consultant	0	21,931	V10A-3	41
42	Respiratory Therapy Consultant	0	0		42
43	Speech Therapy Consultant	0	11,600	V10A-3	43
44	Activity Consultant	0	2,025	V11-3	44
45	Social Service Consultant	0	2,697	V12-3	45
46	Other(specify)	0	0		46
47		0	0		47
48		0	0		48
49	TOTAL (lines 35 - 48)		$ 202,957		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		1,500	V10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$ 1,500		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jennifer Banks	Administrator	0	$ 43,730
Miranda Witt	Administrator	0	56,314
Darcy Swaar	Administrator	0	14,786
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 114,830

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
Generations HCN	Bookkeeping Services	$ 73,260
Generations HCN	Financial Services	33,300
Generations HCN	Reimbursement	23,976
Generations HCN	Regulatory Services	11,988
Generations HCN	Computer Support Charges	17,316
Generations HCN	Information Technology	7,992
Generations HCN	Business Development	66,600
Generations HCN	Admin Services	70,596
Generations HCN	Food Service	9,324
Generations HCN	Clinical Service	34,632
Generations HCN	Environmental Service	9,324
Consulting	Consulting Services	12,185
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 370,493

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 59,101
Unemployment Compensation Insurance	
FICA Taxes	284,303
Employee Health Insurance	81,150
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 424,554

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	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Licenses and Permits	
Dues and Subscriptions	1,298
Association Dues - ICLTC	
Advertising and Promotion	2,357
Gen. HCN	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,655

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Travel	10,664
Seminar Expense	140
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,804

* Attach copy of IMRF notifications

**See instructions.

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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? **No**
If YES, give association name and amount.

(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. $ **9,678** 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. $ **227,782**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **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