FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0054866

Facility Name: Generations at McKinley Place, LLC

Address: 2530 North Monroe (Number) Decatur (City) 62526 (Zip Code)

County: Macon

Telephone Number: (217) 875-0920 **Fax #** (217) 876-9351

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 McKinley Place, LLC # 0054866 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	195	Skilled (SNF)	195	71,175	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	195	TOTALS	195	71,175	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	37,898	3,076	8,666	49,640	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,898	3,076	8,666	49,640	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.74%

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 195 and days of care provided 4,523

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 McKinley Place, LLC # 0054866 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	316,970	40,322	18,451	375,743		375,743	(8,829)	366,914			1
2	Food Purchase		403,224		403,224		403,224		403,224			2
3	Housekeeping	269,585		43,150	312,735		312,735	(3,815)	308,920			3
4	Laundry	87,109		37,907	125,016		125,016	(735)	124,281			4
5	Heat and Other Utilities			205,076	205,076		205,076	1,802	206,878			5
6	Maintenance	85,020	112,488		197,508		197,508	2,609	200,117			6
7	Other (specify):*			33,140	33,140		33,140	6,384	39,524			7
8	**TOTAL General Services**	758,684	556,034	337,724	1,652,442		1,652,442	(2,584)	1,649,858			8
	B. Health Care and Programs											
9	Medical Director			17,750	17,750		17,750		17,750			9
10	Nursing and Medical Records	3,670,701	41,120	42,139	3,753,960		3,753,960	(23,969)	3,729,991			10
10a	Therapy			1,146,911	1,146,911		1,146,911	(2,540)	1,144,371			10a
11	Activities	98,717		5,480	104,197		104,197		104,197			11
12	Social Services	44,546		1,249	45,795		45,795		45,795			12
13	CNA Training											13
14	Program Transportation			4,035	4,035		4,035		4,035			14
15	Other (specify):*							7,100	7,100			15
16	**TOTAL Health Care and Programs**	3,813,964	41,120	1,217,564	5,072,648		5,072,648	(19,409)	5,053,239			16
	C. General Administration											
17	Administrative	115,882			115,882		115,882	26,864	142,746			17
18	Directors Fees											18
19	Professional Services			549,323	549,323		549,323	(261,273)	288,050			19
20	Dues, Fees, Subscriptions & Promotions			14,963	14,963		14,963	97	15,060			20
21	Clerical & General Office Expenses	363,756	57,889	204,521	626,166		626,166	(90,705)	535,461			21
22	Employee Benefits & Payroll Taxes			690,726	690,726		690,726	(174)	690,552			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,950	6,950		6,950	241	7,191			24
25	Other Admin. Staff Transportation							15,379	15,379			25
26	Insurance-Prop.Liab.Malpractice			181,742	181,742		181,742	1,565	183,307			26
27	Other (specify):*			50,990	50,990		50,990	22,614	73,604			27
28	**TOTAL General Administration**	479,638	57,889	1,699,215	2,236,742		2,236,742	(285,392)	1,951,350			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,052,286	655,043	3,254,503	8,961,832		8,961,832	(307,385)	8,654,447			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 McKinley Place, 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			33,140	33,140
Alloc. - Generations HCN			6,384	6,384
Employee Benefits				-
				-
				-
				-
				-
Sub-Total	-	-	39,524	39,524
Line 15 - Other Health Care Services				
Alloc. - Generations HCN			7,100	7,100
Employee Benefits				-
				-
				-
				-
				-
				-
Sub-Total	-	-	7,100	7,100
Line 27 - Other General Administration				
Other Administrative			50,990	50,990
				-
				-
Alloc. - Generations HCN			22,614	22,614
Employee Benefits				-
				-
				-
Sub-Total	-	-	73,604	73,604

Facility Name & ID Number Generations at McKinley Place, LLC #0054866 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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			1,832	1,832		1,832	187,506	189,338			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53,718	53,718		53,718	132,291	186,009			32
33	Real Estate Taxes			159,756	159,756		159,756	11,899	171,655			33
34	Rent-Facility & Grounds			270,000	270,000		270,000	(270,000)				34
35	Rent-Equipment & Vehicles			54,587	54,587		54,587	3,631	58,218			35
36	Other (specify):*			944	944		944	(944)				36
37	**TOTAL Ownership**			540,837	540,837		540,837	64,383	605,220			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	40,526	105,933	147,077	293,536		293,536	(6,635)	286,901			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			380,623	380,623		380,623		380,623			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	40,526	105,933	527,700	674,159		674,159	(6,635)	667,524			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,092,812	760,976	4,323,040	10,176,828		10,176,828	(249,637)	9,927,191			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 McKinley Place, LLC # 0054866 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 Reference	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	(944)	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	(185,344)	21		24
25	Fund Raising, Advertising and Promotional	(10,380)	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	(36,923)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (233,591)		$	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)	(16,046)	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (16,046)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (249,637)		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 McKinley Place, LLC

ID# 0054866

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	(5,078)	19	3
4	Bank Fees	(4,864)	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	(10,404)	19	13
14	Dues and Subscriptions	(116)	20	14
15	Amortization	(16,461)	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**	(36,923)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Generations at McKinley Place, LLC # 0054866 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	(7,478)	0	(1,351)	0	0	0	0	0	(8,829)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	(3,815)	0	0	0	0	0	(3,815)	3
4	Laundry	0	0	0	0	0	(735)	0	0	0	0	0	(735)	4
5	Heat and Other Utilities	0	0	0	1,802	0	0	0	0	0	0	0	1,802	5
6	Maintenance	0	0	(1,617)	5,668	0	(1,442)	0	0	0	0	0	2,609	6
7	Other (specify):*	0	0	1,053	5,331	0	0	0	0	0	0	0	6,384	7
8	**TOTAL General Services**	0	0	(564)	5,323	0	(7,343)	0	0	0	0	0	(2,584)	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	(19,346)	6,769	(1,756)	(9,636)	0	0	0	0	0	(23,969)	10
10a	Therapy	0	0	0	(2,540)	0	0	0	0	0	0	0	(2,540)	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	5,112	1,988	0	0	0	0	0	0	0	7,100	15
16	**TOTAL Health Care and Programs**	0	0	(14,234)	6,217	(1,756)	(9,636)	0	0	0	0	0	(19,409)	16
	C. General Administration													
17	Administrative	0	0	(77,939)	104,803	0	0	0	0	0	0	0	26,864	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(15,482)	10,404	(268,902)	12,707	0	0	0	0	0	0	0	(261,273)	19
20	Fees, Subscriptions & Promotions	(116)	116	97	0	0	0	0	0	0	0	0	97	20
21	Clerical & General Office Expenses	(190,208)	0	99,407	96	0	0	0	0	0	0	0	(90,705)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	(174)	0	0	0	0	0	0	(174)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	241	0	0	0	0	0	0	0	0	241	24
25	Other Admin. Staff Transportation	0	0	15,379	0	0	0	0	0	0	0	0	15,379	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,342	223	0	0	0	0	0	0	0	1,565	26
27	Other (specify):*	(10,380)	0	8,464	24,530	0	0	0	0	0	0	0	22,614	27
28	**TOTAL General Administration**	(216,186)	10,520	(221,911)	142,359	(174)	0	0	0	0	0	0	(285,392)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(216,186)	10,520	(236,709)	153,899	(1,930)	(16,979)	0	0	0	0	0	(307,385)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Generations at McKinley Place, LLC # 0054866 **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	182,663	0	4,843	0	0	0	0	0	0	0	187,506	30
31	Amortization of Pre-Op. & Org.	(16,461)	16,461	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	153,025	(25,123)	4,389	0	0	0	0	0	0	0	132,291	32
33	Real Estate Taxes	0	4,923	0	6,976	0	0	0	0	0	0	0	11,899	33
34	Rent-Facility & Grounds	0	(270,000)	0	0	0	0	0	0	0	0	0	(270,000)	34
35	Rent-Equipment & Vehicles	0	0	3,631	0	0	0	0	0	0	0	0	3,631	35
36	Other (specify):*	(944)	0	0	0	0	0	0	0	0	0	0	(944)	36
37	**TOTAL Ownership**	(17,405)	87,072	(21,492)	16,208	0	0	0	0	0	0	0	64,383	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	(6,635)	0	0	0	0	0	0	(6,635)	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	(6,635)	0	0	0	0	0	0	(6,635)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(233,591)	97,592	(258,201)	170,107	(8,565)	(16,979)	0	0	0	0	0	(249,637)	45

Facility Name & ID Number Generations at McKinley Place, LLC # 0054866 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	$ 270,000	Generations Healthcare Property of Decatur, LLC		$	$ (270,000)	1
2	V	33	Real Estate Taxes	159,756	Generations Healthcare Property of Decatur, LLC		164,679	4,923	2
3	V	19	Professional Fees		Generations Healthcare Property of Decatur, LLC		10,404	10,404	3
4	V	20	Dues and Subscriptions		Generations Healthcare Property of Decatur, LLC		116	116	4
5	V	30	Depreciation		Generations Healthcare Property of Decatur, LLC		182,663	182,663	5
6	V	31	Amortization		Generations Healthcare Property of Decatur, LLC		16,461	16,461	6
7	V	32	Interest		Generations Healthcare Property of Decatur, LLC		153,025	153,025	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 429,756			$ 527,348	$ * 97,592	14

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

Facility Name & ID Number Generations at McKinley Place, LLC # 0054866 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 McKinley Place, LLC # 0054866 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.	$ 13,440	GENERATIONS HC NETWORK, LLC		$ 11,823	$ (1,617)	15
16	V	7	EMP. BEN.-GEN. SERV.		GENERATIONS HC NETWORK, LLC		1,053	1,053	16
17	V	9	MEDICAL DIRECTOR CONSULTS		GENERATIONS HC NETWORK, LLC				17
18	V	10	NURSING	49,920	GENERATIONS HC NETWORK, LLC		30,574	(19,346)	18
19	V	15	EMP. BEN.-H.C.		GENERATIONS HC NETWORK, LLC		5,112	5,112	19
20	V	17	ADMINISTRATIVE	101,760	GENERATIONS HC NETWORK, LLC		23,821	(77,939)	20
21	V	19	PROFESSIONAL FEES	278,400	GENERATIONS HC NETWORK, LLC		9,498	(268,902)	21
22	V	20	FEES, SUBSCRIPTIONS		GENERATIONS HC NETWORK, LLC		97	97	22
23	V	21	CLERICAL & GENERAL	34,560	GENERATIONS HC NETWORK, LLC		133,967	99,407	23
24	V	24	EDUCATION & SEMINAR		GENERATIONS HC NETWORK, LLC		241	241	24
25	V	25	OTHER ADMIN. STAFF TRANS.		GENERATIONS HC NETWORK, LLC		15,379	15,379	25
26	V	26	INSURANCE		GENERATIONS HC NETWORK, LLC		1,342	1,342	26
27	V	27	EMP. BEN.-GEN. ADMIN.		GENERATIONS HC NETWORK, LLC		8,464	8,464	27
28	V	32	INTEREST		GENERATIONS HC NETWORK, LLC		(25,123)	(25,123)	28
29	V	35	AUTO RENTAL		GENERATIONS HC NETWORK, LLC		2,928	2,928	29
30	V	35	EQUIPMENT RENTAL		GENERATIONS HC NETWORK, LLC		703	703	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			$ 478,080			$ 219,879	$ * (258,201)	39

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

Facility Name & ID Number Generations at McKinley Place, LLC # 0054866 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	$ 13,440	GENERATIONS HC NETWORK, LLC		$ 5,962	$ (7,478)	15
16	V	7	EMP. BEN.-DIETARY		GENERATIONS HC NETWORK, LLC		998	998	16
17	V	10	NURSING SALARIES		GENERATIONS HC NETWORK, LLC		6,769	6,769	17
18	V	15	EMP. BEN.-NURSING		GENERATIONS HC NETWORK, LLC		1,126	1,126	18
19	V	17	ADMIN./LEGAL SALARIES		GENERATIONS HC NETWORK, LLC		104,803	104,803	19
20	V	19	FIN. CONSULT./REGL. DIR.		GENERATIONS HC NETWORK, LLC		12,438	12,438	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		GENERATIONS HC NETWORK, LLC		24,530	24,530	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	7,680	GENERATIONS HC NETWORK, LLC		5,140	(2,540)	24
25	V	15	EMPLOYEE BENEFITS		GENERATIONS HC NETWORK, LLC		862	862	25
26	V								26
27	V	6	MAINTENANCE SALARIES	19,915	GENERATIONS HC NETWORK, LLC		24,541	4,626	27
28	V	7	EMPLOYEE BENEFITS		GENERATIONS HC NETWORK, LLC		4,333	4,333	28
29	V								29
30	V	5	UTILITIES		GENERATIONS HC NETWORK, LLC		1,802	1,802	30
31	V	6	REPAIRS AND MANT.		GENERATIONS HC NETWORK, LLC		1,042	1,042	31
32	V	19	PROFESSIONAL FEES		GENERATIONS HC NETWORK, LLC		269	269	32
33	V	21	CLERICAL & GENERAL		GENERATIONS HC NETWORK, LLC		96	96	33
34	V	26	INSURANCE		GENERATIONS HC NETWORK, LLC		223	223	34
35	V	30	DEPRECIATION		GENERATIONS HC NETWORK, LLC		4,843	4,843	35
36	V	32	INTEREST		GENERATIONS HC NETWORK, LLC		4,389	4,389	36
37	V	33	REAL ESTATE TAXES		GENERATIONS HC NETWORK, LLC		6,976	6,976	37
38	V								38
39	Total			$ 41,035			$ 211,142	$ * 170,107	39

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

Facility Name & ID Number Generations at McKinley Place, LLC # 0054866 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	20,378	MAC Rx, LLC		18,622	(1,756)	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	2,017	MAC Rx, LLC		1,843	(174)	20
21	V	39	Ancillary	76,983	MAC Rx, LLC		70,348	(6,635)	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			$ 99,378			$ 90,813	$ * (8,565)	39

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

Facility Name & ID Number Generations at McKinley Place, LLC # 0054866 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	$ 14,109	Big Ten Supply, LLC		$ 12,758	$ (1,351)	15
16	V	3	Housekeeping	39,848	Big Ten Supply, LLC		36,033	(3,815)	16
17	V	4	Laundry	7,678	Big Ten Supply, LLC		6,943	(735)	17
18	V	6	Repairs & Maintenance	15,056	Big Ten Supply, LLC		13,614	(1,442)	18
19	V	10	Nursing and Medical Records	100,624	Big Ten Supply, LLC		90,988	(9,636)	19
20	V	10A	Therapy		Big Ten Supply, LLC				20
21	V	21	Clerical & General		Big Ten Supply, LLC				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			$ 177,315			$ 160,336	$ * (16,979)	39

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

Facility Name & ID Number Generations at McKinley Place, LLC # 0054866 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	1.95	6.10	Salary	$ 2,854	21-7	1
2	Joey Abramchik	Relative	Administrative	0.00	See Attachment	2.44	6.10	Salary	12,438	17-7	2
3	Bryan Barrish	Relative	Administrative	0.00	See Attachment	2.14	5.34	Salary	15,256	17-7	3
4	Sarah Barrish	Relative	Administrative	0.00	See Attachment	3.05	6.10	Salary	7,673	17-7	4
5	Louise Bergthold	Relative	Administrative	0.00	See Attachment	3.66	6.10	Salary	15,256	17-7	5
6	Thomas Bergthold	Relative	Clerical	0.00	See Attachment	2.44	6.10	Salary	3,018	21-7	6
7	Andrew Chin	Relative	Clerical	0.00	See Attachment	2.44	6.10	Salary	5,121	21-7	7
8	Fay Chin	Relative	Nursing	0.00	See Attachment	2.44	6.10	Salary	6,769	10-7	8
9	Clark Collins	Relative	Administrative	0.00	See Attachment	2.51	6.27	Salary	3,136	Var.	9
10	Lynn Ethell	Relative	Clerical	0.00	See Attachment	1.83	6.10	Salary	3,092	21-7	10
11	Michael Giannini	Relative	Administrative	0.00	See Attachment	2.14	5.34	Salary	11,033	17-7	11
12	Nenita Guzman	Relative	Dietary	0.00	See Attachment	3.05	6.10	Salary	5,962	1-7	12
13								TOTAL	$ 91,608		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 McKinley Place, LLC # 0054866 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	2.44	6.10	Salary	$ 8,565	17-7	1
2	Kristen Schloss	Relative	Maintenance	0.00	See Attachment	2.44	6.10	Salary	6,294	6-7	2
3	Kim Shelton	Relative	Clerical	0.00	See Attachment	2.75	6.10	Salary	4,705	21-7	3
4	Thomas Winter	Owner	Administrative	0.00	See Attachment	3.66	6.10	Salary	15,256	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 34,820		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 McKinley Place, LLC # 0054866 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 Decatur, LL
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 McKinley Place, LLC # 0054866 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	49,640	$ 11,823	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	813,429	20	17,260		49,640	1,053	2
3	9	MEDICAL DIRECTOR CONSUL	PATIENT DAYS	813,429	20			49,640		3
4	10	NURSING	PATIENT DAYS	813,429	20	501,001	501,001	49,640	30,574	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	813,429	20	83,773		49,640	5,112	5
6	17	ADMINISTRATIVE	PATIENT DAYS	813,429	20	390,351	390,351	49,640	23,821	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	813,429	20	155,641		49,640	9,498	7
8	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	813,429	20	1,590		49,640	97	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	813,429	20	2,195,251	1,959,905	49,640	133,967	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	813,429	20	3,956		49,640	241	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	813,429	20	252,011		49,640	15,379	11
12	26	INSURANCE	PATIENT DAYS	813,429	20	21,989		49,640	1,342	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	813,429	20	138,692		49,640	8,464	13
14	32	INTEREST	PATIENT DAYS	813,429	20	(411,674)		49,640	(25,123)	14
15	35	AUTO RENTAL	PATIENT DAYS	813,429	20	47,983		49,640	2,928	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	813,429	20	11,512		49,640	703	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		$ 219,879	25

Facility Name & ID Number Generations at McKinley Place, LLC # 0054866 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	49,640	$ 5,962	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	813,429	20	16,359		49,640	998	2
3	10	NURSING SALARIES	PATIENT DAYS	813,429	20	110,913	110,913	49,640	6,769	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	813,429	20	18,452		49,640	1,126	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	813,429	20	1,717,366	1,717,366	49,640	104,803	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	813,429	20	203,820		49,640	12,438	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	813,429	20	401,962		49,640	24,530	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	284,688	14	190,531	190,531	7,680	5,140	10
11	15	EMPLOYEE BENEFITS	SPECIAL REHAB INC.	284,688	14	31,950		7,680	862	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANC INC.	368,277	19	453,836	453,836	19,915	24,542	13
14	7	EMPLOYEE BENEFITS	MAINTENANC INC.	368,277	19	80,131		19,915	4,333	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	20	29,526		786	1,802	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	20	17,073		786	1,042	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	20	4,403		786	269	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	20	1,572		786	96	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	20	3,650		786	223	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	20	79,352		786	4,843	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	20	71,924		786	4,389	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	20	114,307		786	6,976	23
24										24
25	TOTALS					$ 3,644,817	$ 2,570,336		$ 211,143	25

Facility Name & ID Number Generations at McKinley Place, LLC # 0054866 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						18,622	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						1,843	6
7	39	Ancillary	Direct Allocation						70,348	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					$	$		$ 90,813	25

Facility Name & ID Number Generations at McKinley Place, LLC # 0054866 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			$	$		$ 12,758	1
2	3	Housekeeping	Direct Allocation						36,033	2
3	4	Laundry	Direct Allocation						6,943	3
4	6	Repairs & Maintenance	Direct Allocation						13,614	4
5	10	Nursing and Medical Records	Direct Allocation						90,988	5
6	10A	Therapy	Direct Allocation							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					$	$		$ 160,336	25

Facility Name & ID Number Generations at McKinley Place, LLC # 0054866 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			$ 3,262,500	$ 3,262,500	7/27/21	5.5000	$ 7,854	1
2	Republic Bank		X	Line of Credit			77,666	77,666	7/27/21	5.2500	834	2
3												3
4												4
5												5
	Working Capital											
6	Sharedholder Loans	X		Line of Credit							73,937	6
7												7
8												8
9	TOTAL Facility Related						$ 3,340,166	$ 3,340,166			$ 82,625	9
	B. Non-Facility Related*											
10	Alloc. SIR / Generations	X									32,984	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 32,984	14
15	TOTALS (line 9+line14)						$ 3,340,166	$ 3,340,166			$ 115,609	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 McKinley Place, LLC # 0054866 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.**	$ 169,309	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.)		$ 166,343	2
3. Under or (over) accrual (line 2 minus line 1).		$ (2,966)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 174,621	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.		$ 171,655	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	74,873	8
	2014	73,581	9
	2015	154,700	10
	2016	162,797	11
	2017		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 = $159,756
Alloc. SIR Management = $6,587

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 McKinley Place, LLC COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0054866

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.	04-12-03-251-014	Long Term Care Facility	$ 159,755.58	$ 159,755.58
2.	Alloc. - SIR Management	Long Term Care Facility	$ 107,928.00	$ 6,587.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 267,683.58	$ 166,342.58

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 McKinley Place, LLC # 0054866 Report Period Beginning: 01/01/18 Ending: 12/31/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,720 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 5

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	$ 75,000	1
2					2
3	TOTALS			$ 75,000	3

Facility Name & ID Number Generations at McKinley Place, LLC # 0054866 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	195		2018		$ 3,362,500	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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											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 McKinley Place, LLC # 0054866 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)		$ 3,362,500	$		$	$	$	70

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

Facility Name & ID Number Generations at McKinley Place, LLC # 0054866 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		$ 3,362,500	$		$	$	$	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)		$ 3,362,500	$		$	$	$	34

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

Facility Name & ID Number Generations at McKinley Place, LLC # 0054866 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		$ 3,362,500	$		$	$	$	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	FS Depreciation - Generations at McKinley Place, LLC			1,832		1,832		1,832	28
29	FS Depreciation - Generations Healthcare Property of Deactur, LLC			182,663		182,663		182,663	29
30	FS Depreciation - SIR Mgmt / Generations HC Network, LLC			7,181		7,181		122,525	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,362,500	$ 191,676		$ 191,676	$	$ 307,020	34

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

Facility Name & ID Number Generations at McKinley Place, LLC # 0054866 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	21,695						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 21,695	$	$	$		$	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)	$ 3,459,195	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 191,676	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 191,676	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)	$ 307,020	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 McKinley Place, LLC # 0054866 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: $ 703 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		$	$ 2,928	17
18					18
19					19
20					20
21	TOTAL		$	$ 2,928	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 McKinley Place, LLC # 0054866 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	6,757	$ 541,778	$ 0	6,757	$ 541,778	1
2	Licensed Speech and Language Development Therapist	V10A	0.00	hrs	0	621	50,945	0	621	50,945	2
3	Licensed Recreational Therapist	V10A	0.00	hrs	0	0	0	0			3
4	Licensed Physical Therapist	V10A	0.00	hrs	0	7,091	551,648	0	7,091	551,648	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation	V39	#####	hrs	29,487	0	0	0	1,916	29,487	8
9	Pharmacy	V39	0.00	# of prescrpts	0	0	0	150,167		150,167	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	1,314		1,314	12
13	Other (specify): BILLABLE SUPPLIES	V39	0.00		0	0	0	105,933		105,933	13
14	TOTAL				$ 29,487	14,469	$ 1,144,371	$ 257,414	16,385	$ 1,431,272	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 McKinley Place, LLC # 0054866 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	$ 86,286	$ 218,625	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,250,942	2,250,942	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	(27,638)	(27,638)	6
7	Other Prepaid Expenses	7,465	7,465	7
8	Accounts Receivable (owners or related parties)		384,800	8
9	Other(specify):	(360,861)	(360,861)	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,956,194	$ 2,473,333	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		75,000	13
14	Buildings, at Historical Cost		3,287,500	14
15	Leasehold Improvements, at Historical Cost		211,559	15
16	Equipment, at Historical Cost	21,695	1,038,185	16
17	Accumulated Depreciation (book methods)	(1,832)	(184,495)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		45,169	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(9,034)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	439,081	551,688	22
23	Other(specify):	17,378	17,378	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 476,322	$ 5,032,950	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,432,516	$ 7,506,283	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 282,823	$ 282,821	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,150,000	1,589,081	29
30	Accrued Salaries Payable	281,416	281,416	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,668	10,668	31
32	Accrued Real Estate Taxes(Sch.IX-B)		184,000	32
33	Accrued Interest Payable		13,253	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	20,092	20,092	35
	Other Current Liabilities(specify):			
36				36
37		85,191	85,191	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,830,190	$ 2,466,522	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		77,666	39
40	Mortgage Payable		3,262,500	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44		64,727	64,727	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 64,727	$ 3,404,893	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,894,917	$ 5,871,415	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 537,599	$ 1,634,868	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,432,516	$ 7,506,283	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)	75,772	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**	461,825	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 537,597	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)**	$ 537,597	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	$ 9,380,999	1
2	Discounts and Allowances for all Levels	(2,458,202)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,922,797	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,180,721	6
7	Oxygen	2,508	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,183,229	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	127,409	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	332	19
20	Radiology and X-Ray	599	20
21	Other Medical Services	18,234	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 146,574	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)**	$ 10,252,600	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,652,442	31
32	Health Care	5,072,648	32
33	General Administration	2,236,742	33
	B. Capital Expense		
34	Ownership	540,837	34
	C. Ancillary Expense		
35	Special Cost Centers	293,536	35
36	Provider Participation Fee	380,623	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,176,828	40
41	**Income before Income Taxes (line 30 minus line 40)****	75,772	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 75,772	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,902,560	44
45	Private Pay - Net Inpatient Revenue	554,981	45
46	Medicare - Net Inpatient Revenue	2,261,500	46
47	Other-(specify) ALL OTHER SNF/SCF IP REVENUE	661,958	47
48	Other-(specify) C/A ANCILLARY ACCOUNTS	(2,458,202)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,922,797	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	1,600	1,768	$ 84,729	$ 47.92	1
2	Assistant Director of Nursing	517	531	18,058	34.01	2
3	Registered Nurses	11,604	12,608	423,400	33.58	3
4	Licensed Practical Nurses	44,577	48,337	1,341,147	27.75	4
5	CNAs & Orderlies	104,705	112,824	1,644,575	14.58	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	286	331	11,039	33.35	7
8	Rehab/Therapy Aides	1,653	1,916	29,487	15.39	8
9	Activity Director	0	0	0		9
10	Activity Assistants	7,151	7,718	98,717	12.79	10
11	Social Service Workers	2,036	2,285	44,546	19.49	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	24,854	27,192	316,970	11.66	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	3,569	3,729	85,020	22.80	17
18	Housekeepers	23,351	25,041	269,585	10.77	18
19	Laundry	7,749	8,509	87,109	10.24	19
20	Administrator	1,977	2,091	115,882	55.42	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	18,127	20,488	363,756	17.75	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	4,238	4,808	158,791	33.03	31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	257,994	280,176	$ 5,092,811 *	$ 18.18	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	$ 18,451	V01-3	35
36	Medical Director	0	17,750	V09-3	36
37	Medical Records Consultant	0	0		37
38	Nurse Consultant	0	0		38
39	Pharmacist Consultant	0	11,460	V10-3	39
40	Physical Therapy Consultant	0	11,049	V10A-3	40
41	Occupational Therapy Consultant	0	15,623	V10A-3	41
42	Respiratory Therapy Consultant	0	0		42
43	Speech Therapy Consultant	0	3,525	V10A-3	43
44	Activity Consultant	0	2,197	V11-3	44
45	Social Service Consultant	0	1,249	V12-3	45
46	Other(specify)	0	0		46
47		0	0		47
48		0	0		48
49	TOTAL (lines 35 - 48)		$ 81,304		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kim Auton	Administrator	0	$ 115,882
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 115,882

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	$ 105,600
Generations HCN	Financial Services	48,000
Generations HCN	Reimbursement	34,560
Generations HCN	Regulatory Services	17,280
Generations HCN	Computer Support Charges	24,960
Generations HCN	Information Technology	11,520
Generations HCN	Business Development	96,000
Generations HCN	Admin Services	53,760
Generations HCN	Food Service	13,440
Generations HCN	Clinical Service	49,920
Generations HCN	Environmental Service	13,440
Consulting	Consulting Services	80,843
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 549,323

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 97,501
Unemployment Compensation Insurance	
FICA Taxes	422,623
Employee Health Insurance	170,428
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 690,552

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	12,825
Association Dues - ICLTC	
Advertising and Promotion	2,235
Gen. HCN	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,060

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Travel	6,950
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,950

* 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. $ **16,086** 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. $ **380,623**
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