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: 0049973

Facility Name: Generations at Neighbors, LLC

Address: 801 West 2nd Street (Number) Byron (City) 61010 (Zip Code)

County: Ogle

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: 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 Neighbors, LLC # 0049973 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	131	Skilled (SNF)	131	47,815	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	131	TOTALS	131	47,815	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED	19,665	4,992	8,527	33,184	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,665	4,992	8,527	33,184	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.40%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 131 and days of care provided 3,701

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: 12/31/18 Fiscal Year: 12/31/18

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

Facility Name & ID Number Generations at Neighbors, LLC # 0049973 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	273,488	26,603	11,493	311,584		311,584	3,985	315,569			1
2	Food Purchase		237,702		237,702		237,702		237,702			2
3	Housekeeping	173,328		22,024	195,352		195,352	(1,595)	193,757			3
4	Laundry	105,927		29,609	135,536		135,536		135,536			4
5	Heat and Other Utilities			145,403	145,403		145,403	1,204	146,607			5
6	Maintenance	32,015	102,188		134,203		134,203	9,380	143,583			6
7	Other (specify):* See Supplemental			7,952	7,952		7,952	2,385	10,337			7
8	**TOTAL General Services**	584,758	366,493	216,481	1,167,732		1,167,732	15,359	1,183,091			8
	B. Health Care and Programs											
9	Medical Director			19,200	19,200		19,200		19,200			9
10	Nursing and Medical Records	2,024,338	33,645	624,081	2,682,064		2,682,064	12,946	2,695,010			10
10a	Therapy			649,074	649,074		649,074		649,074			10a
11	Activities	109,245		11,376	120,621		120,621		120,621			11
12	Social Services	62,406		3,049	65,455		65,455		65,455			12
13	CNA Training											13
14	Program Transportation			8,570	8,570		8,570		8,570			14
15	Other (specify):* See Supplemental							4,171	4,171			15
16	**TOTAL Health Care and Programs**	2,195,989	33,645	1,315,350	3,544,984		3,544,984	17,117	3,562,101			16
	C. General Administration											
17	Administrative	102,407			102,407		102,407	85,984	188,391			17
18	Directors Fees											18
19	Professional Services			292,941	292,941		292,941	(95,153)	197,788			19
20	Dues, Fees, Subscriptions & Promotions			19,045	19,045		19,045	65	19,110			20
21	Clerical & General Office Expenses	186,031	49,013	135,574	370,618		370,618	(68,320)	302,298			21
22	Employee Benefits & Payroll Taxes			461,301	461,301		461,301	(296)	461,005			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,920	2,920		2,920	161	3,081			24
25	Other Admin. Staff Transportation							10,281	10,281			25
26	Insurance-Prop.Liab.Malpractice			67,012	67,012		67,012	1,046	68,058			26
27	Other (specify):* See Supplemental			55,133	55,133		55,133	8,407	63,540			27
28	**TOTAL General Administration**	288,438	49,013	1,033,926	1,371,377		1,371,377	(57,825)	1,313,552			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,069,185	449,151	2,565,757	6,084,093		6,084,093	(25,349)	6,058,744			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 Neighbors, 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			7,952	7,952
Alloc. - Generations HCN				-
Employee Benefits			2,385	2,385
				-
				-
				-
				-
Sub-Total	-	-	10,337	10,337
Line 15 - Other Health Care Services				
Alloc. - Generations HCN				-
Employee Benefits			4,171	4,171
				-
				-
				-
				-
				-
Sub-Total	-	-	4,171	4,171
Line 27 - Other General Administration				
Other Administrative			55,133	55,133
				-
				-
Alloc. - Generations HCN				-
Employee Benefits			8,407	8,407
				-
				-
Sub-Total	-	-	63,540	63,540

Facility Name & ID Number Generations at Neighbors, LLC #0049973 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			48,265	48,265		48,265	436,253	484,518			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			164,476	164,476		164,476	711,180	875,656			32
33	Real Estate Taxes			140,000	140,000		140,000	106,368	246,368			33
34	Rent-Facility & Grounds			1,068,000	1,068,000		1,068,000	(1,068,000)				34
35	Rent-Equipment & Vehicles			63,561	63,561		63,561	2,427	65,988			35
36	Other (specify):*			769	769		769	(769)				36
37	**TOTAL Ownership**			1,485,071	1,485,071		1,485,071	187,459	1,672,530			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	115,249	129,755	226,670	471,674		471,674	(10,083)	461,591			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			250,684	250,684		250,684		250,684			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	115,249	129,755	477,354	722,358		722,358	(10,083)	712,275			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,184,434	578,906	4,528,182	8,291,522		8,291,522	152,027	8,443,549			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 Neighbors, LLC # 0049973 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	(769)	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	(967)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(124,151)	21		24
25	Fund Raising, Advertising and Promotional	(12,682)	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	(97,167)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (235,736)		$	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)	387,763	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 387,763		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 152,027		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 Neighbors, LLC

ID# 0049973

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	(2,128)	19	3
4	Bank Fees	(11,958)	21	4
5		0		5
6		0		6
7		0		7
8		0		8
9		0		9
10		0		10
11		0		11
12	Neighbors Property, LLC - Non Allowable	0		12
13	Professional Fees	(32,893)	19	13
14	Dues and Subscriptions	(75)	20	14
15	Amortization	(50,113)	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**	(97,167)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Generations at Neighbors, LLC # 0049973 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	3,985	0	0	0	0	0	0	0	3,985	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	(1,595)	0	0	0	0	0	(1,595)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	1,204	0	0	0	0	0	0	0	1,204	5
6	Maintenance	0	0	7,904	1,779	0	(303)	0	0	0	0	0	9,380	6
7	Other (specify):*	0	0	704	1,681	0	0	0	0	0	0	0	2,385	7
8	**TOTAL General Services**	0	0	8,608	8,649	0	(1,898)	0	0	0	0	0	15,359	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	20,438	4,525	(2,192)	(9,825)	0	0	0	0	0	12,946	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	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	3,418	753	0	0	0	0	0	0	0	4,171	15
16	**TOTAL Health Care and Programs**	0	0	23,856	5,278	(2,192)	(9,825)	0	0	0	0	0	17,117	16
	C. General Administration													
17	Administrative	0	0	15,924	70,060	0	0	0	0	0	0	0	85,984	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(35,021)	32,893	(101,519)	8,494	0	0	0	0	0	0	0	(95,153)	19
20	Fees, Subscriptions & Promotions	(75)	75	65	0	0	0	0	0	0	0	0	65	20
21	Clerical & General Office Expenses	(136,109)	0	67,740	64	(15)	0	0	0	0	0	0	(68,320)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	(296)	0	0	0	0	0	0	(296)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	161	0	0	0	0	0	0	0	0	161	24
25	Other Admin. Staff Transportation	0	0	10,281	0	0	0	0	0	0	0	0	10,281	25
26	Insurance-Prop.Liab.Malpractice	0	0	897	149	0	0	0	0	0	0	0	1,046	26
27	Other (specify):*	(13,649)	0	5,658	16,398	0	0	0	0	0	0	0	8,407	27
28	**TOTAL General Administration**	(184,854)	32,968	(793)	95,165	(311)	0	0	0	0	0	0	(57,825)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(184,854)	32,968	31,671	109,092	(2,503)	(11,723)	0	0	0	0	0	(25,349)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Generations at Neighbors, LLC # 0049973 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	433,018	0	3,235	0	0	0	0	0	0	0	436,253	30
31	Amortization of Pre-Op. & Org.	(50,113)	50,113	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	725,042	(16,794)	2,932	0	0	0	0	0	0	0	711,180	32
33	Real Estate Taxes	0	101,708	0	4,660	0	0	0	0	0	0	0	106,368	33
34	Rent-Facility & Grounds	0	(1,068,000)	0	0	0	0	0	0	0	0	0	(1,068,000)	34
35	Rent-Equipment & Vehicles	0	0	2,427	0	0	0	0	0	0	0	0	2,427	35
36	Other (specify):*	(769)	0	0	0	0	0	0	0	0	0	0	(769)	36
37	TOTAL Ownership	(50,882)	241,881	(14,367)	10,827	0	0	0	0	0	0	0	187,459	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	(10,083)	0	0	0	0	0	0	(10,083)	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	(10,083)	0	0	0	0	0	0	(10,083)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(235,736)	274,849	17,304	119,919	(12,586)	(11,723)	0	0	0	0	0	152,027	45

Facility Name & ID Number Generations at Neighbors, LLC # 0049973 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	$ 1,068,000	Neighbors Property, LLC		$	$ (1,068,000)	1
2	V	33	Real Estate Taxes	140,000	Neighbors Property, LLC		241,708	101,708	2
3	V	19	Professional Fees		Neighbors Property, LLC		32,893	32,893	3
4	V	20	Dues and Subscriptions		Neighbors Property, LLC		75	75	4
5	V	30	Depreciation		Neighbors Property, LLC		433,018	433,018	5
6	V	31	Amortization		Neighbors Property, LLC		50,113	50,113	6
7	V	32	Interest		Neighbors Property, LLC		725,042	725,042	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,208,000			$ 1,482,849	$ * 274,849	14

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

Facility Name & ID Number Generations at Neighbors, LLC # 0049973 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			Albany Care, Inc.	Cook, IL				1
2	Atied Associates, LLC	36.28%	Generations at Applewood, LLC	Matteson, IL	Generations Prop.	Lincolnwood, IL	Bldg. Company	2
3	Barrish Group Limited Property	12.75%	Auburn Village	Auburn, IL	Generations HC			3
4	Bryan Barrish Trust D/T/D 09/01/04	12.75%	Bryan Mawr Care, Inc.	Chicago, IL	Transitions	Lincolnwood, IL	Mgmt. Company	4
5	Michael Giannini Trust	10.79%	Generations At Columbus Park, Inc.	Chicago, IL	SIR Management	Lincolnwood, IL	Mgmt. Company	5
6	Ralph Gesualdo	12.75%	Decatur Manor Healthcare, LLC	Decatur, IL	SIR Properties	Lincolnwood, IL	Bldg. Company	6
7	Ralph Gesualdo Children Trust	12.75%	Generations at Elmwood Park, Inc.	Elmwood Park, IL	Max RX, LLC	Des Plaines, IL	Pharmacy	7
8	Thomas Winter	1.94%	Greenwood Care, Inc.	Evanston, IL	LTC Lab, LLC	Lincolnwood, IL	Ancillary Supplies	8
9			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 Neighbors, LLC # 0049973 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.	$	GENERATIONS HC NETWORK, LLC		$ 7,904	$ 7,904	15
16	V	7	EMP. BEN.-GEN. SERV.		GENERATIONS HC NETWORK, LLC		704	704	16
17	V	9	MEDICAL DIRECTOR CONSULTS		GENERATIONS HC NETWORK, LLC				17
18	V	10	NURSING		GENERATIONS HC NETWORK, LLC		20,438	20,438	18
19	V	15	EMP. BEN.-H.C.		GENERATIONS HC NETWORK, LLC		3,418	3,418	19
20	V	17	ADMINISTRATIVE		GENERATIONS HC NETWORK, LLC		15,924	15,924	20
21	V	19	PROFESSIONAL FEES	107,868	GENERATIONS HC NETWORK, LLC		6,349	(101,519)	21
22	V	20	FEES, SUBSCRIPTIONS		GENERATIONS HC NETWORK, LLC		65	65	22
23	V	21	CLERICAL & GENERAL	21,816	GENERATIONS HC NETWORK, LLC		89,556	67,740	23
24	V	24	EDUCATION & SEMINAR		GENERATIONS HC NETWORK, LLC		161	161	24
25	V	25	OTHER ADMIN. STAFF TRANS.		GENERATIONS HC NETWORK, LLC		10,281	10,281	25
26	V	26	INSURANCE		GENERATIONS HC NETWORK, LLC		897	897	26
27	V	27	EMP. BEN.-GEN. ADMIN.		GENERATIONS HC NETWORK, LLC		5,658	5,658	27
28	V	32	INTEREST		GENERATIONS HC NETWORK, LLC		(16,794)	(16,794)	28
29	V	35	AUTO RENTAL		GENERATIONS HC NETWORK, LLC		1,957	1,957	29
30	V	35	EQUIPMENT RENTAL		GENERATIONS HC NETWORK, LLC		470	470	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			$ 129,684			$ 146,988	$ * 17,304	39

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

Facility Name & ID Number Generations at Neighbors, LLC # 0049973 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	$	GENERATIONS HC NETWORK, LLC		$ 3,985	$ 3,985	15
16	V	7	EMP. BEN.-DIETARY		GENERATIONS HC NETWORK, LLC		667	667	16
17	V	10	NURSING SALARIES		GENERATIONS HC NETWORK, LLC		4,525	4,525	17
18	V	15	EMP. BEN.-NURSING		GENERATIONS HC NETWORK, LLC		753	753	18
19	V	17	ADMIN./LEGAL SALARIES		GENERATIONS HC NETWORK, LLC		70,060	70,060	19
20	V	19	FIN. CONSULT./REGL. DIR.		GENERATIONS HC NETWORK, LLC		8,315	8,315	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		GENERATIONS HC NETWORK, LLC		16,398	16,398	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB		GENERATIONS HC NETWORK, LLC				24
25	V	15	EMPLOYEE BENEFITS		GENERATIONS HC NETWORK, LLC				25
26	V								26
27	V	6	MAINTENANCE SALARIES	4,662	GENERATIONS HC NETWORK, LLC		5,745	1,083	27
28	V	7	EMPLOYEE BENEFITS		GENERATIONS HC NETWORK, LLC		1,014	1,014	28
29	V								29
30	V	5	UTILITIES		GENERATIONS HC NETWORK, LLC		1,204	1,204	30
31	V	6	REPAIRS AND MANT.		GENERATIONS HC NETWORK, LLC		696	696	31
32	V	19	PROFESSIONAL FEES		GENERATIONS HC NETWORK, LLC		179	179	32
33	V	21	CLERICAL & GENERAL		GENERATIONS HC NETWORK, LLC		64	64	33
34	V	26	INSURANCE		GENERATIONS HC NETWORK, LLC		149	149	34
35	V	30	DEPRECIATION		GENERATIONS HC NETWORK, LLC		3,235	3,235	35
36	V	32	INTEREST		GENERATIONS HC NETWORK, LLC		2,932	2,932	36
37	V	33	REAL ESTATE TAXES		GENERATIONS HC NETWORK, LLC		4,660	4,660	37
38	V								38
39	Total			$ 4,662			$ 124,581	$ * 119,919	39

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

Facility Name & ID Number Generations at Neighbors, LLC # 0049973 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	25,431	MAC Rx, LLC		23,239	(2,192)	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	177	MAC Rx, LLC		162	(15)	19
20	V	22	Employee Benefits	3,427	MAC Rx, LLC		3,131	(296)	20
21	V	39	Ancillary	116,992	MAC Rx, LLC		106,909	(10,083)	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			$ 146,027			$ 133,441	$ * (12,586)	39

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

Facility Name & ID Number Generations at Neighbors, LLC # 0049973 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	$	Big Ten Supply, LLC		$	$	15
16	V	3	Housekeeping	16,652	Big Ten Supply, LLC		15,057	(1,595)	16
17	V	4	Laundry		Big Ten Supply, LLC				17
18	V	6	Repairs & Maintenance	3,164	Big Ten Supply, LLC		2,861	(303)	18
19	V	10	Nursing and Medical Records	102,596	Big Ten Supply, LLC		92,771	(9,825)	19
20	V	10A	Therapy		Big Ten Supply, LLC				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			$ 122,412			$ 110,689	$ * (11,723)	39

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

Facility Name & ID Number Generations at Neighbors, LLC # 0049973 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	1.31	4.08	Salary	$ 1,908	21-7	1
2	Joey Abramchik	Relative	Administrative	0.00	See Attachment	1.63	4.08	Salary	8,315	17-7	2
3	Bryan Barrish	Relative	Administrative	0.00	See Attachment	1.43	3.57	Salary	10,199	17-7	3
4	Sarah Barrish	Relative	Administrative	0.00	See Attachment	2.04	4.08	Salary	5,130	17-7	4
5	Louise Bergthold	Relative	Administrative	0.00	See Attachment	2.45	4.08	Salary	10,199	17-7	5
6	Thomas Bergthold	Relative	Clerical	0.00	See Attachment	1.63	4.08	Salary	2,017	21-7	6
7	Andrew Chin	Relative	Clerical	0.00	See Attachment	1.63	4.08	Salary	3,423	21-7	7
8	Fay Chin	Relative	Nursing	0.00	See Attachment	1.63	4.08	Salary	4,525	10-7	8
9	Clark Collins	Relative	Administrative	0.00	See Attachment	1.73	4.33	Salary	2,165	Var.	9
10	Lynn Ethell	Relative	Clerical	0.00	See Attachment	1.22	4.08	Salary	2,067	21-7	10
11	Michael Giannini	Relative	Administrative	0.00	See Attachment	1.43	3.57	Salary	7,376	17-7	11
12	Nenita Guzman	Relative	Dietary	0.00	See Attachment	2.04	4.08	Salary	3,985	1-7	12
13								TOTAL	$ 61,309		13

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

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

Facility Name & ID Number Generations at Neighbors, LLC # 0049973 Report Period Beginning: 01/01/18 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	1.63	4.08	Salary	$ 5,726	17-7	1
2	Kristen Schloss	Relative	Maintenance	0.00	See Attachment	1.63	4.08	Salary	4,207	6-7	2
3	Kim Shelton	Relative	Clerical	0.00	See Attachment	1.84	4.08	Salary	3,145	21-7	3
4	Thomas Winter	Owner	Administrative	1.94	See Attachment	2.45	4.08	Salary	10,199	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 23,277		13

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

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

Facility Name & ID Number Generations at Neighbors, LLC # 0049973 Report Period Beginning: 01/01/18 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: Neighbors Property, LLC
Street Address: 6840 N. Lincoln
City / State / Zip Code: Lincolnwood, Illinois 60712
Phone Number: (847) 675 - 7979
Fax Number: (847) 675 - 0555

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

Facility Name & ID Number Generations at Neighbors, LLC # 0049973 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	33,184	$ 7,904	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	813,429	20	17,260		33,184	704	2
3	9	MEDICAL DIRECTOR CONSUL	PATIENT DAYS	813,429	20			33,184		3
4	10	NURSING	PATIENT DAYS	813,429	20	501,001	501,001	33,184	20,438	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	813,429	20	83,773		33,184	3,418	5
6	17	ADMINISTRATIVE	PATIENT DAYS	813,429	20	390,351	390,351	33,184	15,924	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	813,429	20	155,641		33,184	6,349	7
8	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	813,429	20	1,590		33,184	65	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	813,429	20	2,195,251	1,959,905	33,184	89,556	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	813,429	20	3,956		33,184	161	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	813,429	20	252,011		33,184	10,281	11
12	26	INSURANCE	PATIENT DAYS	813,429	20	21,989		33,184	897	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	813,429	20	138,692		33,184	5,658	13
14	32	INTEREST	PATIENT DAYS	813,429	20	(411,674)		33,184	(16,794)	14
15	35	AUTO RENTAL	PATIENT DAYS	813,429	20	47,983		33,184	1,957	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	813,429	20	11,512		33,184	470	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		$ 146,988	25

Facility Name & ID Number Generations at Neighbors, LLC # 0049973 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	33,184	$ 3,985	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	813,429	20	16,359		33,184	667	2
3	10	NURSING SALARIES	PATIENT DAYS	813,429	20	110,913	110,913	33,184	4,525	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	813,429	20	18,452		33,184	753	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	813,429	20	1,717,366	1,717,366	33,184	70,060	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	813,429	20	203,820		33,184	8,315	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	813,429	20	401,962		33,184	16,398	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	284,688	14	190,531	190,531			10
11	15	EMPLOYEE BENEFITS	SPECIAL REHAB INC.	284,688	14	31,950				11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANC INC.	368,277	19	453,836	453,836	4,662	5,745	13
14	7	EMPLOYEE BENEFITS	MAINTENANC INC.	368,277	19	80,131		4,662	1,014	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	20	29,526		525	1,204	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	20	17,073		525	696	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	20	4,403		525	179	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	20	1,572		525	64	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	20	3,650		525	149	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	20	79,352		525	3,235	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	20	71,924		525	2,932	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	20	114,307		525	4,660	23
24										24
25	TOTALS					$ 3,644,817	$ 2,570,336		$ 124,581	25

Facility Name & ID Number Generations at Neighbors, LLC # 0049973 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						23,239	2
3	10A	Therapy	Direct Allocation							3
4	19	Professional Services	Direct Allocation							4
5	21	Clerical & General Office Expense	Direct Allocation						162	5
6	22	Employee Benefits	Direct Allocation						3,131	6
7	39	Ancillary	Direct Allocation						106,909	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					$	$		$ 133,441	25

Facility Name & ID Number Generations at Neighbors, LLC # 0049973 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			$	$		$	1
2	3	Housekeeping	Direct Allocation						15,057	2
3	4	Laundry	Direct Allocation							3
4	6	Repairs & Maintenance	Direct Allocation						2,861	4
5	10	Nursing and Medical Records	Direct Allocation						92,771	5
6	10A	Therapy	Direct Allocation							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					$	$		$ 110,689	25

Facility Name & ID Number Generations at Neighbors, LLC # 0049973 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	Private Bank		X	Mortgage		12/01/16	$ 11,635,822	$ 11,643,400		6.3495	$ 725,042	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Private Bank		X	Line of Credit				1,000,000		5.5000	134,850	6
7												7
8	Shareholder Loans	X		Line of Credit				3,470,000				8
9	TOTAL Facility Related						$ 11,635,822	$ 16,113,400			$ 859,892	9
	B. Non-Facility Related*											
10	Alloc. Generations HCN	X									15,764	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 15,764	14
15	TOTALS (line 9+line14)						$ 11,635,822	$ 16,113,400			$ 875,656	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 Neighbors, LLC # 0049973 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.**	$ 75,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 246,108	2
3. Under or (over) accrual (line 2 minus line 1).		$ 171,108	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 75,260	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.		$ 246,368	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	59,072	8
	2014	59,839	9
	2015	64,236	10
	2016	67,798	11
	2017	63,497	12

Real Estate Tax-Current=$157,200
Real Estate Tax-Prior=$84,508
Alloc. SIR Management = $4,400

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

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 Neighbors, LLC COUNTY Ogle

FACILITY IDPH LICENSE NUMBER 0049973

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.	05-31-201-006	Long Term Care Facility	$ 157,151.20	$ 157,151.20
2.	Alloc. - SIR Management	Long Term Care Facility	$ 107,928.00	$ 4,399.60
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 265,079.20	$ 161,550.80

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 Neighbors, LLC # 0049973 Report Period Beginning: 01/01/18 Ending: 12/31/18

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Generations at Neighbors, LLC # 0049973 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	131		2008	1971	$ 2,175,000	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2008	30,221						9
10	Various			2009	31,966						10
11	Various			2010	29,530						11
12	Various			2011	286,651						12
13	Various			2012	83,020						13
14	Anti Freeze Loop Sprinkler			2013	3,397						14
15	HVAC Roof-Top Units			2013	9,471						15
16	Door Holders and Alarm Devices			2013	2,653						16
17	Security System			2013	5,790						17
18	Seal Coating & Asphalt Repairs			2013	3,778						18
19	Plumbing Backflow Device			2013	2,716						19
20	10 Air Conditioners			2013	5,525						20
21	Drainage Tile Installation & Gutter Repair			2013	2,627						21
22	Backflow Device			2014	3,198						22
23	Parking Lot Paving			2014	14,321						23
24	Doors			2014	2,549						24
25	Boiler Repair - New Valve, Pump, and Bearing Assembly			2015	3,401						25
26	Northern Mechanical - Hot Water Heater			2016	9,506						26
27	Landmark Construction - Skylight Smoke Detector			2017	8,800						27
28	Shower room tiles			2018	35,327						28
29	Landscaping			2018	5,095						29
30	Kitchen Tile			2018	14,167						30
31											31
32	Neighbors Property, LLC										32
33	Drywall / Hallways 100 & 400			2014	44,751						33
34	Drywall / Hallways 200 & 300			2015	43,700						34
35	Construction - Bed Addition (30) Building Demolition and Rebuild			2016	10,179,462						35
36	Landmark Construction - Additional project work			2017	84,052						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 Neighbors, LLC # 0049973 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)		$ 13,120,674	$		$	$	$	70

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

Facility Name & ID Number Generations at Neighbors, LLC # 0049973 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		$ 13,120,674	$		$	$	$	1
2									2
3	SIR Mgmt / Generations HC Network, LLC								3
4									4
5	Various	1993	3,841						5
6	Various	1994	12						6
7	Various	1995	88						7
8	Various	1997	5,902						8
9	Various	1999	16,734						9
10	Various	1999	464						10
11	Various	1999							11
12	Various	2000	548						12
13	Various	2007	1,760						13
14	Various	2008	4,852						14
15	Various	2009	12,055						15
16	Various	2011	298						16
17	Various	2012	954						17
18	Various	2014	134						18
19	Various	2016	174						19
20									20
21	SIR Mgmt / Generations HC Network, LLC								21
22									22
23	Various	1993	15,150						23
24	Various	1993	246						24
25	Various	1994	144						25
26	Various	1997	57						26
27	Various	1998	917						27
28	Various	1999	1,920						28
29	Various	2002	60						29
30	Various	2007	265						30
31	Various	2009	910						31
32	Various	2010	914						32
33	Various	2012	928						33
34	TOTAL (lines 1 thru 33)		$ 13,190,001	$		$	$	$	34

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

Facility Name & ID Number Generations at Neighbors, LLC # 0049973 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		$ 13,190,001	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30	FS Depreciation - Generations at Neighbors, LLC			48,265		48,265		322,743	30
31	FS Depreciation - Neighbors Properties, LLC			433,018		433,018		2,165,505	31
32	FS Depreciation - SIR Mgmt / Generations HC Network, LLC			4,796		4,796		81,840	32
33									33
34	TOTAL (lines 1 thru 33)		$ 13,190,001	$ 486,079		$ 486,079	$	$ 2,570,088	34

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

Facility Name & ID Number Generations at Neighbors, LLC # 0049973 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	$ 1,376,871	$	$	$		$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Alloc. - Generations HCN							74
75	TOTALS	$ 1,376,871	$	$	$		$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2012 Dodge Minivan	2012	$ 19,000	$	$	$		$	76
77	Generations HCN			1,403						77
78										78
79										79
80	TOTALS			$ 20,403	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 14,757,275	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 486,079	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 486,079	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,570,088	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 Neighbors, LLC # 0049973 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: $ 470 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		$	$ 1,957	17
18					18
19					19
20					20
21	TOTAL		$	$ 1,957	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 Neighbors, LLC # 0049973 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	3,361	$ 244,041	$ 0	3,361	$ 244,041	1
2	Licensed Speech and Language Development Therapist	V10A	0.00	hrs	0	327	23,735	0	327	23,735	2
3	Licensed Recreational Therapist	V10A	0.00	hrs	0	0	0	0			3
4	Licensed Physical Therapist	V10A	0.00	hrs	0	5,251	381,297	0	5,251	381,297	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation	V39	#####	hrs	115,249	0	0	11,042	5,588	126,291	8
9	Pharmacy	V39	0.00	# of prescrpts	0	0	0	192,697		192,697	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	12,849		12,849	12
13	Other (specify): BILLABLE SUPPLIES	V39	0.00		0	0	0	129,755		129,755	13
14	TOTAL				$ 115,249	8,939	$ 649,073	$ 346,343	14,527	$ 1,110,665	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 Neighbors, LLC # 0049973 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	$ 54,757	$ 1,087,159	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,693,278	1,693,278	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,313	20,313	6
7	Other Prepaid Expenses	1,990	1,990	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	12,882		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,783,220	$ 2,802,740	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		170,000	13
14	Buildings, at Historical Cost		2,480,000	14
15	Leasehold Improvements, at Historical Cost	549,748	10,960,548	15
16	Equipment, at Historical Cost	296,755	1,069,147	16
17	Accumulated Depreciation (book methods)	(322,743)	(2,488,248)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	1,939,586	1,939,586	22
23	Other(specify):	3,575	3,575	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,466,921	$ 14,134,608	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,250,141	$ 16,937,348	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 392,886	$ 392,886	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	4,470,000	4,470,000	29
30	Accrued Salaries Payable	173,622	173,622	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,785	8,785	31
32	Accrued Real Estate Taxes(Sch.IX-B)		157,200	32
33	Accrued Interest Payable		59,561	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	15,133		35
	Other Current Liabilities(specify):			
36				36
37	Other Liabilities	139,687	139,684	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,200,113	$ 5,401,738	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,643,400	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Tax	8,500	8,500	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 8,500	$ 11,651,900	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,208,613	$ 17,053,638	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (958,472)	$ (116,290)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,250,141	$ 16,937,348	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (755,641)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (755,641)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,277,191)	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)	1,074,360	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (202,831)	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)**	$ (958,472)	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	$ 6,832,935	1
2	Discounts and Allowances for all Levels	(1,740,515)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,092,420	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,689,478	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,689,478	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	178,023	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,663	19
20	Radiology and X-Ray	5,699	20
21	Other Medical Services	34,048	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 232,433	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)**	$ 7,014,331	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,167,732	31
32	Health Care	3,544,984	32
33	General Administration	1,371,377	33
	B. Capital Expense		
34	Ownership	1,485,071	34
	C. Ancillary Expense		
35	Special Cost Centers	471,674	35
36	Provider Participation Fee	250,684	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,291,522	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,277,191)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,277,191)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,926,411	44
45	Private Pay - Net Inpatient Revenue	1,051,207	45
46	Medicare - Net Inpatient Revenue	1,815,613	46
47	Other-(specify) ALL OTHER SNF/SCF IP REVENUE	1,039,704	47
48	Other-(specify) C/A ANCILLARY ACCOUNTS	(1,740,515)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,092,420	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	1,696	1,819	$ 97,278	$ 53.48	1
2	Assistant Director of Nursing	1,147	1,225	43,094	35.18	2
3	Registered Nurses	4,657	4,738	168,709	35.61	3
4	Licensed Practical Nurses	24,242	24,895	850,156	34.15	4
5	CNAs & Orderlies	49,744	52,557	758,097	14.42	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	5,324	5,588	115,249	20.62	8
9	Activity Director	0	0	0		9
10	Activity Assistants	8,040	8,798	109,245	12.42	10
11	Social Service Workers	2,851	3,300	62,406	18.91	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	20,873	21,553	273,488	12.69	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	1,994	2,086	32,015	15.35	17
18	Housekeepers	13,772	14,525	173,328	11.93	18
19	Laundry	7,481	8,067	105,927	13.13	19
20	Administrator	1,953	2,003	102,359	51.10	20
21	Assistant Administrator	5	5	48	9.60	21
22	Other Administrative	10,896	11,552	186,031	16.10	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	4,418	4,598	107,004	23.27	31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	159,093	167,309	$ 3,184,434 *	$ 19.03	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	$ 11,493	V01-3	35
36	Medical Director	0	19,200	V09-3	36
37	Medical Records Consultant	0	0		37
38	Nurse Consultant	0	0		38
39	Pharmacist Consultant	0	7,117	V10-3	39
40	Physical Therapy Consultant	0	4,713	V10A-3	40
41	Occupational Therapy Consultant	0	1,985	V10A-3	41
42	Respiratory Therapy Consultant	0	0		42
43	Speech Therapy Consultant	0	240	V10A-3	43
44	Activity Consultant	0	2,543	V11-3	44
45	Social Service Consultant	0	3,049	V12-3	45
46	Other(specify)	0	0		46
47		0	0		47
48		0	0		48
49	TOTAL (lines 35 - 48)		$ 50,340		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	497	28,400	V10-3	51
52	Certified Nurse Assistants/Aides	18,540	571,061	V10-3	52
53	TOTAL (lines 50 - 52)	19,037	$ 599,461		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Pawn Thammarath	Administrator	0	$ 102,407
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 102,407

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	$ 66,660
Generations HCN	Financial Services	30,300
Generations HCN	Reimbursement	21,816
Generations HCN	Regulatory Services	10,908
Generations HCN	Computer Support Charges	15,756
Consulting	Consulting Services	147,501
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 292,941

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 46,321
Unemployment Compensation Insurance	
FICA Taxes	259,728
Employee Health Insurance	154,955
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	
Life Insurance	
Retirement Benefits	
TOTAL (agree to Schedule V, line 22, col.8)	$ 461,004

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	9,629
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Licenses and Permits	
Dues and Subscriptions	858
Association Dues - ICLTC	8,623
Advertising and Promotion	
Gen. HCN	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,110

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Travel	2,920
Seminar Expense	161
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,081

* 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? **Yes**
If YES, give association name and amount. **ICLTC - $8,623**

(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. $ **17,054** 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. $ **250,684**
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? **Yes** Indicate the amount. $ **1,057**

(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