FOR BHF USE

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: 0055103

Facility Name: Generations at Riverview

Address: 500 Centennial Drive (Number) East Peoria (City) 61611 (Zip Code)

County: Tazewell

Telephone Number: (309) 694-9865 **Fax #** (309) 699-2191

HFS ID Number:

Date of Initial License for Current Owners: 11/1/2018

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. Leonard, 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 01/01/20 to 12/31/20 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 Leonard, CPA — Partner
(Firm Name & Address) Plante & Moran PLLC — 1111 Superior Avenue Suite 1250 Cleveland OH 44114
(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 Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 N/A

	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	71	Skilled (SNF)	71	25,986	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	71	TOTALS	71	25,986	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	1,200	1,345	11,566	14,111	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,200	1,345	11,566	14,111	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.30%

D. How many bed reserve days during this year were paid by the Department?
None (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)
None

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 11/1/2018

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/1/2018 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 71 and days of care provided 7,520

Medicare Intermediary Novitas Solutions

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number Generations at Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	148,169	18,859	22,298	189,326		189,326	1,178	190,504			1
2	Food Purchase		111,288		111,288		111,288	(4,187)	107,101			2
3	Housekeeping	98,726		17,956	116,682		116,682	(1,635)	115,047			3
4	Laundry	53,657		17,658	71,315		71,315	(475)	70,840			4
5	Heat and Other Utilities			139,704	139,704		139,704	(7,861)	131,843			5
6	Maintenance	62,030	122,956		184,986		184,986	67,583	252,569			6
7	Other (specify):*			21,129	21,129		21,129	13,650	34,779			7
8	**TOTAL General Services**	362,582	253,103	218,745	834,430		834,430	68,253	902,683			8
	B. Health Care and Programs											
9	Medical Director			17,600	17,600		17,600		17,600			9
10	Nursing and Medical Records	1,719,559	89,212	64,895	1,873,666		1,873,666	(8,293)	1,865,373			10
10a	Therapy			884,341	884,341		884,341		884,341			10a
11	Activities	4,491	2,603	2,257	9,351		9,351		9,351			11
12	Social Services	133,092		112	133,204		133,204		133,204			12
13	CNA Training											13
14	Program Transportation			24,046	24,046		24,046		24,046			14
15	Other (specify):*							3,467	3,467			15
16	**TOTAL Health Care and Programs**	1,857,142	91,815	993,251	2,942,208		2,942,208	(4,826)	2,937,382			16
	C. General Administration											
17	Administrative	41,635			41,635		41,635	41,396	83,031			17
18	Directors Fees											18
19	Professional Services			465,232	465,232		465,232	(369,440)	95,792			19
20	Dues, Fees, Subscriptions & Promotions			25,781	25,781		25,781	836	26,617			20
21	Clerical & General Office Expenses	151,192	35,752	28,905	215,849		215,849	58,934	274,783			21
22	Employee Benefits & Payroll Taxes			492,165	492,165		492,165	(192)	491,973			22
23	Inservice Training & Education											23
24	Travel and Seminar			196	196		196	107	303			24
25	Other Admin. Staff Transportation			6,922	6,922		6,922	1,912	8,834			25
26	Insurance-Prop.Liab.Malpractice			215,820	215,820		215,820	608	216,428			26
27	Other (specify):*			11,261	11,261		11,261	3,279	14,540			27
28	**TOTAL General Administration**	192,827	35,752	1,246,282	1,474,861		1,474,861	(262,560)	1,212,301			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,412,551	380,670	2,458,278	5,251,499		5,251,499	(199,133)	5,052,366			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.

Facility Name & ID Number Generations at Riverview #0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			26,084	26,084		26,084	268,546	294,630			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			80,322	80,322		80,322	139,009	219,331			32
33	Real Estate Taxes			80,808	80,808		80,808	3,922	84,730			33
34	Rent-Facility & Grounds			585,773	585,773		585,773	(585,773)				34
35	Rent-Equipment & Vehicles			3,400	3,400		3,400	1,397	4,797			35
36	Other (specify):*			15,837	15,837		15,837	(15,837)				36
37	**TOTAL Ownership**			792,224	792,224		792,224	(188,736)	603,488			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		128,683	672,888	801,571		801,571	(71,467)	730,104			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			57,698	57,698		57,698		57,698			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		128,683	730,586	859,269		859,269	(71,467)	787,802			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,412,551	509,353	3,981,088	6,902,992		6,902,992	(459,336)	6,443,656			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 Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,973)	02		4
5	Telephone, TV & Radio in Resident Rooms	(8,333)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	124,078	30		9
10	Interest and Other Investment Income	(704)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(157)	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				24
25	Fund Raising, Advertising and Promotional	(11,261)	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	(251,188)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (150,538)		$	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)	(308,798)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (308,798)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (459,336)		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 Riverview

ID# 0055103

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Collections Expense	$ (3,662)	19	1
2	Bank Fees	(9,775)	21	2
3	Credit Card Fees	(2,516)	21	3
4	Theft & Damage Loss	(592)	21	4
5	Non-Allowable Interest	(129,442)	32	5
6	Amortization of Financing Costs	(15,680)	36	6
7	Vending Income	(419)	02	7
8	Prior Period Nursing Supplies	(11,790)	10	8
9	Prior Period Radiology	(2,374)	39	9
10	Prior Period Laboratory	(23,858)	39	10
11	Prior Period Pharmacy/Infusion	(1,042)	39	11
12	Capitalized R&M	(2,603)	06	12
13	Non-Allowable Legal	(16,460)	19	13
14	Website Expense	(1,537)	19	14
15	Paradox East Peoria Property-Admin Fees	(14,539)	17	15
16	Paradox East Peoria Property-Audit Fees	(5,202)	19	16
17	Paradox East Peoria Property-A&G Expense	(73)	21	17
18	Paradox East Peoria Property-Amortization	(9,624)	31	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**	(251,188)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Generations at Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	1,761	0	(583)	0	0	0	0	0	1,178	1
2	Food Purchase	(3,392)	0	(795)	0	0	0	0	0	0	0	0	(4,187)	2
3	Housekeeping	0	0	0	0	0	(1,635)	0	0	0	0	0	(1,635)	3
4	Laundry	0	0	0	0	0	(475)	0	0	0	0	0	(475)	4
5	Heat and Other Utilities	(8,333)	0	0	472	0	0	0	0	0	0	0	(7,861)	5
6	Maintenance	(2,603)	0	3,871	66,509	0	(194)	0	0	0	0	0	67,583	6
7	Other (specify):*	0	0	488	13,162	0	0	0	0	0	0	0	13,650	7
8	**TOTAL General Services**	(14,328)	0	3,564	81,903	0	(2,887)	0	0	0	0	0	68,252	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	(11,790)	0	18,576	0	(1,912)	(13,167)	0	0	0	0	0	(8,293)	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	3,467	0	0	0	0	0	0	0	0	3,467	15
16	**TOTAL Health Care and Programs**	(11,790)	0	22,043	0	(1,912)	(13,167)	0	0	0	0	0	(4,826)	16
	C. General Administration													
17	Administrative	(14,539)	14,539	5,894	35,502	0	0	0	0	0	0	0	41,396	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(26,861)	5,202	(351,439)	3,658	0	0	0	0	0	0	0	(369,440)	19
20	Fees, Subscriptions & Promotions	0	0	836	0	0	0	0	0	0	0	0	836	20
21	Clerical & General Office Expenses	(12,956)	73	71,848	30	(61)	0	0	0	0	0	0	58,934	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	(192)	0	0	0	0	0	0	(192)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	107	0	0	0	0	0	0	0	0	107	24
25	Other Admin. Staff Transportation	0	0	1,912	0	0	0	0	0	0	0	0	1,912	25
26	Insurance-Prop.Liab.Malpractice	0	0	550	58	0	0	0	0	0	0	0	608	26
27	Other (specify):*	(11,261)	0	6,308	8,232	0	0	0	0	0	0	0	3,279	27
28	**TOTAL General Administration**	(65,617)	19,814	(263,984)	47,480	(253)	0	0	0	0	0	0	(262,560)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(91,735)	19,814	(238,377)	129,383	(2,165)	(16,054)	0	0	0	0	0	(199,134)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Generations at Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	124,078	143,263	0	1,205	0	0	0	0	0	0	0	268,546	30
31	Amortization of Pre-Op. & Org.	(9,624)	9,624	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(130,146)	268,753	(472)	874	0	0	0	0	0	0	0	139,009	32
33	Real Estate Taxes	0	1,827	0	2,095	0	0	0	0	0	0	0	3,922	33
34	Rent-Facility & Grounds	0	(585,773)	0	0	0	0	0	0	0	0	0	(585,773)	34
35	Rent-Equipment & Vehicles	0	0	1,397	0	0	0	0	0	0	0	0	1,397	35
36	Other (specify):*	(15,837)	0	0	0	0	0	0	0	0	0	0	(15,837)	36
37	**TOTAL Ownership**	(31,529)	(162,306)	925	4,174	0	0	0	0	0	0	0	(188,736)	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	(27,274)	0	0	0	(44,193)	0	0	0	0	0	0	(71,467)	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**	(27,274)	0	0	0	(44,193)	0	0	0	0	0	0	(71,467)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(150,538)	(142,492)	(237,452)	133,557	(46,358)	(16,054)	0	0	0	0	0	(459,337)	45

Facility Name & ID Number Generations at Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

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-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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	Rental Income	$ 585,773	Paradox East Peoria Property	100.00%	$	$ (585,773)	1
2	V	33	Real Estate Taxes	101,561	Paradox East Peoria Property	100.00%	103,388	1,827	2
3	V	17	Admin Fees		Paradox East Peoria Property	100.00%	14,539	14,539	3
4	V	19	Professional Fees		Paradox East Peoria Property	100.00%	5,202	5,202	4
5	V	21	A&G Expenses		Paradox East Peoria Property	100.00%	73	73	5
6	V	30	Depreciation		Paradox East Peoria Property	100.00%	143,263	143,263	6
7	V	31	Amortization		Paradox East Peoria Property	100.00%	9,624	9,624	7
8	V	32	Interest		Paradox East Peoria Property	100.00%	268,753	268,753	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 687,334			$ 544,842	$ * (142,492)	14

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

Facility Name & ID Number Generations at Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	33.33%	Albany Care, Inc.	Evanston, IL	Generations Prop.	Lincolnwood, IL	Bldg. Company	1
2	Barrish Group Limited Partnership	24.63%	Generations at Applewood, LLC	Matteson, IL	Generations HC			2
3	Juliana Barrish	24.63%	Auburn Village	Auburn, IN	Transitions	Lincolnwood, IL	Mgmt. Company	3
4	Michael Giannini	8.70%	Bryan Mawr Care, Inc.	Chicago, IL	SIR Management	Lincolnwood, IL	Mgmt. Company	4
5	Celeste Giannini	8.70%	Decatur Manor Healthcare, LLC	Decatur, IL	SIR Properties	Lincolnwood, IL	Bldg. Company	5
6			Generations at Elmwood Park, Inc.	Elmwood Park, IL	Max RX, LLC	Des Plaines, IL	Pharmacy	6
7			Greenwood Care, Inc.	Evanston, IL	Big Ten Supply	Libertyville, IL	Ancillary Supplies	7
8			Generations at Lincoln, LLC	Lincoln, IL	Paradox E. Peoria Prop	East Peoria	Bldg. Company	8
9			Villa Clara Post Acute	Decatur, IL				9
10			Prairie Creek Manor	Decatur, IL				10
11			Generations at Neighbors, LLC	Byron, IL				11
12			Generations at Oakton Arms, LLC	Des Plaines, IL				12
13			Generations at Oakton Pavillion, LLC	Des Plaines, IL				13
14			Generations at Peoria	Peoria, IL				14
15			Generations at Regency, LLC	Niles, IL				15
16			Wilson Care, Inc.	Chicago, IL				16
17			Generations at Riverview Senior Living	East Peoria, IL				17
18			Generations at Rock Island, LLC	Rock Island, IL				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

Facility Name & ID Number Generations at Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	2	Dietary Other and Rebates	$	Generations Healthcare Network LLC	100.00%	$ (795)	$ (795)	15
16	V	6	Repairs & Maintanence		Generations Healthcare Network LLC	100.00%	3,871	3,871	16
17	V	7	Emp. Ben. - General Svc.		Generations Healthcare Network LLC	100.00%	488	488	17
18	V	9	Medical Director Consults		Generations Healthcare Network LLC	100.00%	0		18
19	V	10	Nursing		Generations Healthcare Network LLC	100.00%	18,576	18,576	19
20	V	15	Emp. Ben. - Health Care		Generations Healthcare Network LLC	100.00%	3,467	3,467	20
21	V	17	Administrative		Generations Healthcare Network LLC	100.00%	5,894	5,894	21
22	V	19	Professional Fees	353,792	Generations Healthcare Network LLC	100.00%	2,353	(351,439)	22
23	V	20	Fee, Subscriptions		Generations Healthcare Network LLC	100.00%	836	836	23
24	V	21	Clerical & General		Generations Healthcare Network LLC	100.00%	71,848	71,848	24
25	V	24	Education & Seminar		Generations Healthcare Network LLC	100.00%	107	107	25
26	V	25	Other Admin. Staff Transportation		Generations Healthcare Network LLC	100.00%	1,912	1,912	26
27	V	26	Insurance		Generations Healthcare Network LLC	100.00%	550	550	27
28	V	27	Emp. Ben. - Gen. Admin.		Generations Healthcare Network LLC	100.00%	6,308	6,308	28
29	V	32	Interest		Generations Healthcare Network LLC	100.00%	(472)	(472)	29
30	V	35	Auto Rental		Generations Healthcare Network LLC	100.00%	1,187	1,187	30
31	V	35	Equipment Rental		Generations Healthcare Network LLC	100.00%	210	210	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 353,792			$ 116,340	$ * (237,452)	39

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

Facility Name & ID Number Generations at Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	5	Utilities	$	Generations Healthcare Network LLC	100.00%	$ 472	$ 472	15
16	V	6	Repairs & Maintenance		Generations Healthcare Network LLC	100.00%	407	407	16
17	V	19	Professional Fees		Generations Healthcare Network LLC	100.00%	115	115	17
18	V	21	Clerical & General		Generations Healthcare Network LLC	100.00%	30	30	18
19	V	25	Auto & Travel		Generations Healthcare Network LLC	100.00%	0		19
20	V	26	Insurance		Generations Healthcare Network LLC	100.00%	58	58	20
21	V	30	Depreciation		Generations Healthcare Network LLC	100.00%	1,205	1,205	21
22	V	32	Interest		Generations Healthcare Network LLC	100.00%	874	874	22
23	V	33	Real Estate Taxes		Generations Healthcare Network LLC	100.00%	2,095	2,095	23
24	V								24
25	V	1	Dietary Salaries		Generations Healthcare Network LLC	100.00%	1,761	1,761	25
26	V	7	Emp. Ben. - Dietary		Generations Healthcare Network LLC	100.00%	329	329	26
27	V	10	Nursing Salaries		Generations Healthcare Network LLC	100.00%	0		27
28	V	15	Emp. Ben. - Nursing		Generations Healthcare Network LLC	100.00%	0		28
29	V	17	Admin./Legal Salaries		Generations Healthcare Network LLC	100.00%	35,502	35,502	29
30	V	19	Fin. Consult./Regl. Dir.		Generations Healthcare Network LLC	100.00%	3,543	3,543	30
31	V	27	Emp. Ben. - Administrative		Generations Healthcare Network LLC	100.00%	8,232	8,232	31
32	V								32
33	V	6	Maintenance Salaries		Generations Healthcare Network LLC	100.00%	66,102	66,102	33
34	V	7	Employee Benefits		Generations Healthcare Network LLC	100.00%	12,833	12,833	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 133,557	$ * 133,557	39

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

Facility Name & ID Number Generations at Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	10	Nursing & Medical Records	$ 20,465	MAC Rx, LLC	100.00%	$ 18,553	$ (1,912)	15
16	V	21	Clerical & General Expenses	656	MAC Rx, LLC	100.00%	595	(61)	16
17	V	22	Employee Benefits	2,058	MAC Rx, LLC	100.00%	1,866	(192)	17
18	V	39	Ancillary	472,860	MAC Rx, LLC	100.00%	428,667	(44,193)	18
19	V								19
20	V								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			$ 496,039			$ 449,681	$ * (46,358)	39

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

Facility Name & ID Number Generations at Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$ 6,065	Big Ten Supply LLC	100.00%	$ 5,482	$ (583)	15
16	V	3	Housekeeping	17,017	Big Ten Supply LLC	100.00%	15,382	(1,635)	16
17	V	4	Laundry	4,949	Big Ten Supply LLC	100.00%	4,474	(475)	17
18	V	6	R&M	2,010	Big Ten Supply LLC	100.00%	1,816	(194)	18
19	V	10	Nursing & Medical Records	136,990	Big Ten Supply LLC	100.00%	123,823	(13,167)	19
20	V								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			$ 167,031			$ 150,977	$ * (16,054)	39

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

Facility Name & ID Number Generations at Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Abramchik	Relative	Clerical	0.00%	See Attachment	3.23	8.17%	Alloc Salary	$ 979	21-7	1
2	Joey Abramchik	Relative	Administrative	0.00%	See Attachment	0.68	1.70%	Alloc Fees	3,543	17-7	2
3	Bryan Barrish	Relative	Administrative	0.00%	See Attachment	0.59	1.48%	Alloc Salary	4,239	17-7	3
4	Sarah Barrish	Relative	Administrative	0.00%	See Attachment	0.85	1.70%	Alloc Salary	2,180	17-7	4
5	Louise Bergthold	Relative	Administrative	0.00%	See Attachment	1.02	1.70%	Alloc Salary	4,239	17-7	5
6	Thomas Bergthold	Relative	Clerical	0.00%	See Attachment	0.68	1.70%	Alloc Salary	1,027	21-7	6
7	Kristen Schloss	Relative	Maintenance	0.00%	See Attachment	0.68	1.70%	Alloc Salary	2,644	6-7	7
8	Kim Shelton	Relative	Clerical	0.00%	See Attachment	0.68	1.70%	Alloc Salary	1,503	21-7	8
9	Burton Barrish	Relative	Administrative	0.00%	See Attachment	0.68	1.70%	Alloc Salary	1,836	17-7	9
10	Lynn Ethell	Relative	Clerical	0.00%	See Attachment	0.68	1.70%	Alloc Salary	1,021	21-7	10
11	Michael Giannini	Owner	Administrative	8.70%	See Attachment	0.68	1.51%	Alloc Salary	3,061	17-7	11
12	Nenita Guzman	Relative	Dietary	0.00%	See Attachment	0.68	1.70%	Alloc Salary	1,761	1-7	12
13								TOTAL	$ 28,033		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 Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	0.68	1.70%	Alloc Salary	$ 1,654	17-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 1,654		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 Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

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: Paradox East Peoria Property
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, IL 60202
Phone Number: (847) 905-3000
Fax Number: ( )

	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 Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	2	Dietary Other and Rebates	Resident Days	832,144	19	$ (46,886)	$	14,111	$ (795)	1
2	6	Repairs & Maintanence	Resident Days	832,144	19	228,292	155,904	14,111	3,871	2
3	7	Emp. Ben. - General Svc.	Resident Days	832,144	19	28,781		14,111	488	3
4	9	Medical Director Consults	Resident Days	832,144	19			14,111		4
5	10	Nursing	Resident Days	832,144	19	1,095,433	1,094,370	14,111	18,576	5
6	15	Emp. Ben. - Health Care	Resident Days	832,144	19	204,429		14,111	3,467	6
7	17	Administrative	Resident Days	832,144	19	347,566	347,566	14,111	5,894	7
8	19	Professional Fees	Resident Days	832,144	19	138,762		14,111	2,353	8
9	20	Fee, Subscriptions	Resident Days	832,144	19	49,284		14,111	836	9
10	21	Clerical & General	Resident Days	832,144	19	4,236,976	3,850,828	14,111	71,848	10
11	24	Education & Seminar	Resident Days	832,144	19	6,287		14,111	107	11
12	25	Other Admin. Staff Transportatior	Resident Days	832,144	19	112,731		14,111	1,912	12
13	26	Insurance	Resident Days	832,144	19	32,419		14,111	550	13
14	27	Emp. Ben. - Gen. Admin.	Resident Days	832,144	19	371,977		14,111	6,308	14
15	32	Interest	Resident Days	832,144	19	(27,854)		14,111	(472)	15
16	35	Auto Rental	Resident Days	832,144	19	70,001		14,111	1,187	16
17	35	Equipment Rental	Resident Days	832,144	19	12,377		14,111	210	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 6,860,575	$ 5,448,668		$ 116,340	25

Facility Name & ID Number Generations at Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	5	Utilities	Alloc Square Footage	12,879	19	$ 27,900	$	218	$ 472	1
2	6	Repairs & Maintenance	Alloc Square Footage	12,879	19	24,049		218	407	2
3	19	Professional Fees	Alloc Square Footage	12,879	19	6,801		218	115	3
4	21	Clerical & General	Alloc Square Footage	12,879	19	1,754		218	30	4
5	25	Auto & Travel	Alloc Square Footage	12,879	19			218		5
6	26	Insurance	Alloc Square Footage	12,879	19	3,403		218	58	6
7	30	Depreciation	Alloc Square Footage	12,879	19	71,181		218	1,205	7
8	32	Interest	Alloc Square Footage	12,879	19	51,631		218	874	8
9	33	Real Estate Taxes	Alloc Square Footage	12,879	19	123,763		218	2,095	9
10										10
11	1	Dietary Salaries	Resident Days	832,144	19	103,820	103,820	14,111	1,761	11
12	7	Emp. Ben. - Dietary	Resident Days	832,144	19	19,413		14,111	329	12
13	10	Nursing Salaries	Resident Days	832,144	19			14,111		13
14	15	Emp. Ben. - Nursing	Resident Days	832,144	19			14,111		14
15	17	Admin./Legal Salaries	Resident Days	832,144	19	2,093,591	2,093,591	14,111	35,502	15
16	19	Fin. Consult./Regl. Dir.	Resident Days	832,144	19	208,920		14,111	3,543	16
17	27	Emp. Ben. - Administrative	Resident Days	832,144	19	485,424		14,111	8,232	17
18										18
19	6	Maintenance Salaries	Maint Revenues	702,930	17	726,469	726,469	63,960	66,102	19
20	7	Employee Benefits	Maint Revenues	702,930	17	141,032		63,960	12,833	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,089,151	$ 2,923,880		$ 133,558	25

Facility Name & ID Number Generations at Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

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, Illnois 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	10	Nursing & Medical Records	Direct Allocation			$	$		$ 18,553	1
2	21	Clerical & General Expenses	Direct Allocation						595	2
3	22	Employee Benefits	Direct Allocation						1,866	3
4	39	Ancillary	Direct Allocation						428,667	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					$	$		$ 449,681	25

Facility Name & ID Number Generations at Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

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, Illnois 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			$	$		$ 5,482	1
2	3	Housekeeping	Direct Allocation						15,382	2
3	4	Laundry	Direct Allocation						4,474	3
4	6	R&M	Direct Allocation						1,816	4
5	10	Nursing & Medical Records	Direct Allocation						123,823	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					$	$		$ 150,977	25

Facility Name & ID Number Generations at Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	M&T		X	Mortgage			$	$ 6,938,329			$ 196,310	1
2												2
3												3
4												4
5												5
	Working Capital											
6	CIBC		X	Line of Credit							20,296	6
7	1st Source		X	Vehicle Loan				25,013			3,026	7
8	Shareholder Loans	X		Working Capital				1,970,806			129,442	8
9	TOTAL Facility Related						$	$ 8,934,148			$ 349,074	9
	B. Non-Facility Related*											
10	Interest Income		X								(704)	10
11	Related Party Interest	X									(129,442)	11
12	Allocated From Generations		X								403	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (129,743)	14
15	TOTALS (line 9+line14)						$	$ 8,934,148			$ 219,331	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

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

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

Facility Name & ID Number Generations at Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 124,688	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.)		$ 81,019	2
3. Under or (over) accrual (line 2 minus line 1).		$ (43,669)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 126,335	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.)		$ 2,064	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.		$ 84,730	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	80,419	8
	2016	81,079	9
	2017	82,896	10
	2018	112,464	11
	2019	80,947	12

Beginning accrual adjusted to account for RSL taxes; 2020 accrual also affected by RSL

Allocated From Generations: $2,095

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Generations at Riverview COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0055103

CONTACT PERSON REGARDING THIS REPORT Denise A. Leonard, 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 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	01-01-14-400-021	Long Term Care Property	$ 354.22	$ 77.93
2.	01-01-23-200-025	Long Term Care Property	$ 367,586.94	$ 80,869.13
3.	10-31-401-046-0000	Regency Allocation	$ 796,746.36	$ 163.86
4.	Allocated- SIR Management	Home Office Allocation	$ 148,905.51	$ 1,973.94
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,313,593.03	$ 83,084.86

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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 Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,083 B. General Construction Type: Exterior Masonry Frame Steel 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).

None

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	$ 910,546	1
2					2
3	TOTALS			$ 910,546	3

Facility Name & ID Number Generations at Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	71		2018	1995	$ 7,501,886	$	39	$ 192,356	$ 192,356	$ 577,068	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Amana Wall Heater- 15,000 BTU PTAC Unit			2019	4,908		20	245	245	490	9
10	Resurface Parking Lot-Concrete/Asphalt/Sewer Rebuild			2019	166,400		20	8,320	8,320	16,640	10
11	Door Locks/Keypad Repair- Therapy Door/Outside with Hardware			2019	3,974		20	199	199	398	11
12	Fire Pump Controller- New Transfer Switch			2020	24,580		20	1,229	1,229	1,229	12
13	Security System Throughout Facility- Wander Guard			2020	4,365		20	218	218	218	13
14	Security System/Camera Installation Throughout Facility			2020	19,765		20	988	988	988	14
15	Awning Replacement- Exterior of Facility			2020	3,188		20	159	159	224	15
16	Custom Kitchen Cabinets and Granite Countertops 300 Wing			2020	38,000		20	1,900	1,900	1,900	16
17	Fire Pump Switch Repair			2020	2,603		20	130	130	130	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	Financial Statement Depreciation- Generations at Riverview					26,084			(26,084)		32
33	Financial Statement Depreciation- Paradox East					143,263			(143,263)		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 Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	Related Party Allocations		$	$		$	$	$	37
38									38
39	Training Building Allocation- Generations Helath Care	2009	8,463	226	39	217	(9)	2,396	39
40	Building Allocation- SIR Properties/Generations Health Care	1993	7,662	243	35	219	(24)	5,801	40
41									41
42	Allocated From SIR Properties/Generations Health Care	2012	469		20	23	23	164	42
43	Allocated From SIR Properties/Generations Health Care	2010	462		20	23	23	216	43
44	Allocated From SIR Properties/Generations Health Care	2009	460		20	23	23	248	44
45	Allocated From SIR Properties/Generations Health Care	2007	45	3	20	2	(1)	29	45
46	Allocated From SIR Properties/Generations Health Care	2002	30		20	2	2	27	46
47	Allocated From SIR Properties/Generations Health Care	1999	971		20	24	24	971	47
48	Allocated From SIR Properties/Generations Health Care	1998			20				48
49	Allocated From SIR Properties/Generations Health Care	1997			20				49
50	Allocated From SIR Properties/Generations Health Care	1994	73	2	20		(2)	73	50
51	Allocated From SIR Properties/Generations Health Care	1993	124	1	20		(1)	124	51
52									52
53	Allocated From Generations Health Care	1993	1,943	54	20		(54)	1,943	53
54	Allocated From Generations Health Care	1994	6		20			6	54
55	Allocated From Generations Health Care	1995	44		20			44	55
56	Allocated From Generations Health Care	1997	2,985	67	20		(67)	2,985	56
57	Allocated From Generations Health Care	1999	235		20	9	9	235	57
58	Allocated From Generations Health Care	1999			20				58
59	Allocated From Generations Health Care	2000	277		20	6	6	277	59
60	Allocated From Generations Health Care	2007	890		20	45	45	587	60
61	Allocated From Generations Health Care	2008	2,454		20	91	91	1,795	61
62	Allocated From Generations Health Care	2009	6,097		20	305	305	3,428	62
63	Allocated From Generations Health Care	2011	151	15	20	15		142	63
64	Allocated From Generations Health Care	2012	483	24	20	24		179	64
65	Allocated From Generations Health Care	2014	68	7	20	3	(4)	22	65
66	Allocated From Generations Health Care	2016	88	4	20	4		19	66
67	Allocated From Generations Health Care	2019	439	22	20	22		27	67
68	Allocated From Generations Health Care	2020	358	7	20	7		7	68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,804,946	$ 170,022		$ 206,809	$ 36,787	$ 621,031	70

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

Facility Name & ID Number Generations at Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 7,804,946	$ 170,022		$ 206,809	$ 36,787	$ 621,031	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
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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)		$ 7,804,946	$ 170,022		$ 206,809	$ 36,787	$ 621,031	34

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

Facility Name & ID Number Generations at Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 7,804,946	$ 170,022		$ 206,809	$ 36,787	$ 621,031	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,804,946	$ 170,022		$ 206,809	$ 36,787	$ 621,031	34

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

Facility Name & ID Number Generations at Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 12C, Carried Forward		$ 7,804,946	$ 170,022		$ 206,809	$ 36,787	$ 621,031	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,804,946	$ 170,022		$ 206,809	$ 36,787	$ 621,031	34

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

Facility Name & ID Number Generations at Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 12D, Carried Forward		$ 7,804,946	$ 170,022		$ 206,809	$ 36,787	$ 621,031	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,804,946	$ 170,022		$ 206,809	$ 36,787	$ 621,031	34

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

Facility Name & ID Number Generations at Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 12E, Carried Forward		$ 7,804,946	$ 170,022		$ 206,809	$ 36,787	$ 621,031	1
2									2
3									3
4									4
5									5
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,804,946	$ 170,022		$ 206,809	$ 36,787	$ 621,031	34

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

Facility Name & ID Number Generations at Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 12F, Carried Forward		$ 7,804,946	$ 170,022		$ 206,809	$ 36,787	$ 621,031	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,804,946	$ 170,022		$ 206,809	$ 36,787	$ 621,031	34

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

Facility Name & ID Number Generations at Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 12G, Carried Forward		$ 7,804,946	$ 170,022		$ 206,809	$ 36,787	$ 621,031	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,804,946	$ 170,022		$ 206,809	$ 36,787	$ 621,031	34

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

Facility Name & ID Number Generations at Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 12H, Carried Forward		$ 7,804,946	$ 170,022		$ 206,809	$ 36,787	$ 621,031	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
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,804,946	$ 170,022		$ 206,809	$ 36,787	$ 621,031	34

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

Facility Name & ID Number Generations at Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 57,183	$	$ 5,718	$ 5,718	10	$ 14,650	71
72	Current Year Purchases	12,824		1,282	1,282	10	1,282	72
73	Fully Depreciated Assets					10		73
74	See Attached	716,759	364	69,463	69,099	10	230,974	74
75	TOTALS	$ 786,766	$ 364	$ 76,464	$ 76,100		$ 246,907	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	2018 Ford T350 XI Wagon	2018	$ 55,280	$	$ 11,056	$ 11,056	5	$ 33,168	76
77	Allocated From Generations		2020	1,996	166	301	135		1,069	77
78										78
79										79
80	TOTALS			$ 57,276	$ 166	$ 11,357	$ 11,191		$ 34,237	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,559,533	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 170,552	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 294,630	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 124,078	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 902,175	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 Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 3,610 Description: $2,000 Compactor; $1,400 Printer/Copier; $210 Allocated From Generations
(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	Allocated From Generations		$	$ 1,187	17
18					18
19					19
20					20
21	TOTAL		$	$ 1,187	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 Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	V10A	hrs	$	4,752	$ 369,995	$	4,752	$ 369,995	1
2	Licensed Speech and Language Development Therapist	V10A	hrs		1,105	83,032		1,105	83,032	2
3	Licensed Recreational Therapist	V10A	hrs							3
4	Licensed Physical Therapist	V10A	hrs		5,562	431,313		5,562	431,313	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	V39	hrs				6,488		6,488	8
9	Pharmacy	V39	# of prescrpts				560,049		560,049	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LAB/RADIOLOGY	V39					106,351		106,351	12
13	Other (specify): BILLABLE SUPPLIES	V39					128,683		128,683	13
14	TOTAL			$	11,419	$ 884,340	$ 801,571	11,419	$ 1,685,911	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.

STATE OF ILLINOIS

Facility Name & ID Number Generations at Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (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	$ 429,386	$ 429,386	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,211,817	2,211,817	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	90,745	90,745	6
7	Other Prepaid Expenses	9,170	9,170	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	228,253	596,194	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,969,371	$ 3,337,312	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		910,546	13
14	Buildings, at Historical Cost		7,501,886	14
15	Leasehold Improvements, at Historical Cost	261,206	261,206	15
16	Equipment, at Historical Cost	126,309	819,336	16
17	Accumulated Depreciation (book methods)	(40,672)	(741,527)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	25,600	179,426	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(25,600)	(73,213)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe See Attached			22
23	Other(specify): See Attached	78,625	2,691,599	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 425,468	$ 11,549,259	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,394,839	$ 14,886,571	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 445,400	$ 445,400	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	25,013	25,013	29
30	Accrued Salaries Payable	195,748	195,748	30
31	Accrued Taxes Payable (excluding real estate taxes)	125,101	125,101	31
32	Accrued Real Estate Taxes(Sch.IX-B)		367,941	32
33	Accrued Interest Payable		39,074	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	1,749	1,749	35
	Other Current Liabilities(specify):			
36	See Attached			36
37	See Attached	3,295,404	3,751,883	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,088,415	$ 4,951,909	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,970,806	39
40	Mortgage Payable		6,938,329	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached		750,000	43
44	See Attached			44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 9,659,135	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,088,415	$ 14,611,043	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (693,576)	$ 275,528	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,394,839	$ 14,886,571	48

*(See instructions.)

Facility Name & ID Number Generations at Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (516,287)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (516,287)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(177,289)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (177,289)	17
	B. Transfers (Itemize):		
18			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)**	$ (693,576)	24 *

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

Facility Name & ID Number Generations at Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 6,060,684	1
2	Discounts and Allowances for all Levels	(3,177,354)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,883,330	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,518,440	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,518,440	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	2,973	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	527,506	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	55,143	19
20	Radiology and X-Ray	21,381	20
21	Other Medical Services	38,302	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 645,305	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	704	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 704	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a		677,924	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 677,924	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,725,703	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	834,430	31
32	Health Care	2,942,208	32
33	General Administration	1,474,861	33
	B. Capital Expense		
34	Ownership	792,224	34
	C. Ancillary Expense		
35	Special Cost Centers	801,571	35
36	Provider Participation Fee	57,698	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,902,992	40
41	**Income before Income Taxes (line 30 minus line 40)****	(177,289)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (177,289)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 140,539	44
45	Private Pay - Net Inpatient Revenue	362,656	45
46	Medicare - Net Inpatient Revenue	3,991,141	46
47	Other-(specify) ALL OTHER SNF/SCF IP REVENUE	1,786,759	47
48	Other-(specify) C/A ANCILLARY ACCOUNTS	(3,397,766)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,883,330	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Not Complete **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Generations at Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	1,981	2,094	$ 96,160	$ 45.92	1
2	Assistant Director of Nursing	1,934	2,019	78,432	38.85	2
3	Registered Nurses	14,444	15,419	554,227	35.94	3
4	Licensed Practical Nurses	12,168	13,564	390,062	28.76	4
5	CNAs & Orderlies	27,192	29,222	451,285	15.44	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	253	253	4,491	17.75	10
11	Social Service Workers	6,077	7,057	133,092	18.86	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	9,881	10,690	148,169	13.86	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,990	2,091	62,030	29.67	17
18	Housekeepers	7,758	8,417	98,726	11.73	18
19	Laundry	4,369	4,755	53,657	11.28	19
20	Administrator	898	923	41,635	45.11	20
21	Assistant Administrator					21
22	Other Administrative	6,715	7,050	124,077	17.60	22
23	Office Manager	1,327	1,437	27,115	18.87	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,392	5,661	149,393	26.39	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	102,379	110,652	$ 2,412,551 *	$ 21.80	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	Monthly Fees	$ 22,298	V01-03	35
36	Medical Director	Monthly Fees	19,200	V09-03	36
37	Medical Records Consultant	Monthly Fees	1,928	V10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly Fees	3,456	V10-03	39
40	Physical Therapy Consultant	Monthly Fees	279	V10A-03	40
41	Occupational Therapy Consultant	Monthly Fees	287	V10A-03	41
42	Respiratory Therapy Consultant	Monthly Fees	6,488	V39-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly Fees	2,257	V11-03	44
45	Social Service Consultant	Monthly Fees	112	V12-03	45
46	Other(specify)				46
47	Chief Medical Officer	Monthly Fees	49,140	V10-03	47
48	Restorative Nursing	Monthly Fees	90	V10-03	48
49	TOTAL (lines 35 - 48)		$ 105,535		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	79	$ 3,634	V10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	212	6,645	V10-03	52
53	TOTAL (lines 50 - 52)	291	$ 10,279		53

Facility Name & ID Number Generations at Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Blake Lopeman (Jan-July)	Administrator	0.00%	$ 12,086
Charles Turpin (July-December)	Administrator	0.00%	29,549
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 41,635

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 HC Network	Consultant-Clinical	$ 26,412
Generations HC Network	Director-Environment Services	7,668
Generations HC Network	Outside Labor	2,520
Generations HC Network	Director of Food Service	10,224
Generations HC Network	Dir. of Financial Services	23,004
Generations HC Network	Dir. of Business Development	60,492
Generations HC Network	Dir. of Reimbursement	15,336
Generations HC Network	Dir. of Administrative Services	29,820
Generations HC Network	Dir. of Regulatory Services	8,520
Generations HC Network	Dir.-Information Technology	5,112
Generations HC Network	Ancillary Admin Charges	17,300
See Supplemental Page 21		258,824
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 465,232

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 55,477
Unemployment Compensation Insurance	44,107
FICA Taxes	193,187
Employee Health Insurance	176,289
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	150
Other Employe Benefits and COVID	22,763
TOTAL (agree to Schedule V, line 22, col.8)	$ 491,973

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,992
Advertising: Employee Recruitment	16,247
Health Care Worker Background Check	5,032
(Indicate # of checks performed 503)	
Patient Background Checks	
Dues and Subscriptions	945
Licenses and Permits	1,565
Allocated From Generations	836
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,617

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	196
Allocated From Generations	107
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 303

**See instructions.

Facility Name & ID Number Generations at Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

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

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 HC Network	Bookkeeping Services	$ 59,640
Generations HC Network	Bookkeeping-Other	69,000
Generations HC Network	Computer Support Charges	18,744
Personnel Planners	Unemployment Tax Consult	2,850
See Attached	Legal Services	22,554
Plante Moran	Accounting Fees	20,640
Go Daddy	Website (Adjusted)	1,537
Reside Admissions	Admissions Consultant	4,805
Marcum	401K Audit	500
Crane & Norcross	RE Tax Appeal	1,973
Paylocity	Payroll Processing	11,491
See Supplemental Page 21 (2)		45,090
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 258,824

D. Employee Benefits and Payroll Taxes

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

* Attach copy of IMRF notifications

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	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$

G. Schedule of Travel and Seminar**

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

**See instructions.

Facility Name & ID Number Generations at Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

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

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
Onshift	HR Consulting	$ 2,358
Mack Communication	Telecommunications	9,634
iSolved	HR Consulting	408
Healthstream/Providigm	Quality Management	3,300
Ability Network	Risk Management	6,690
Achieve	Scheduling	3,413
Patient Ping	Resident Management	7,600
Access One	Telecommunications	8,727
Playbook Communicate	Productivity Consulting	2,960
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 45,090

D. Employee Benefits and Payroll Taxes

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

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

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	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$

G. Schedule of Travel and Seminar**

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

**See instructions.

Facility Name & ID Number Generations at Riverview # 0055103 Report Period Beginning: 01/01/20 Ending: 12/31/20

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **18,134** Line **10-2**

(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. $ **57,698**
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. $ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,973**

(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? **ln14 100%**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
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 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.