		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.

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

I. IDPH License ID Number: 0049866

Facility Name: Generations at Rock Island

Address: 2545 24th Street (Number) Rock Island (City) 61201 (Zip Code)

County: Rock Island

Telephone Number: (309) 788-0458 Fax # (309) 788-5234

HFS ID Number:

Date of Initial License for Current Owners: 3/6/1997

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: Steven N. Lavenda Telephone Number: (847) 282-6300
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) 05/23/2021 (Date)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title) Steven N. Lavenda, CPA
Partner
(Firm Name & Address) Marcum, LLP
9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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 Rock Island # 0049866 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	177	Skilled (SNF)	177	64,782	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	177	TOTALS	177	64,782	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	25,579	1,077	5,144	31,800	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,579	1,077	5,144	31,800	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 49.09%

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 03/06/1997

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/06/1997 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 177 and days of care provided 3,084

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number: Generations at Rock Island # 0049866 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	321,944	58,302	20,463	400,709		400,709	3,363	404,072			1
2	Food Purchase		290,782		290,782		290,782	(1,890)	288,892			2
3	Housekeeping	128,779	39,369		168,148		168,148	(3,684)	164,464			3
4	Laundry	45,098	22,016		67,114		67,114	(1,334)	65,780			4
5	Heat and Other Utilities			174,179	174,179		174,179	(15,622)	158,557			5
6	Maintenance	82,979	19,402	140,797	243,178		243,178	20,404	263,582			6
7	Other (specify):*							2,754	2,754			7
8	TOTAL General Services	578,800	429,871	335,439	1,344,110		1,344,110	3,991	1,348,101			8
	B. Health Care and Programs											
9	Medical Director			60,500	60,500		60,500		60,500			9
10	Nursing and Medical Records	1,865,692	251,640	1,382,658	3,499,990		3,499,990	12,964	3,512,954			10
10a	Therapy	78,901		27,009	105,910		105,910	(753)	105,157			10a
11	Activities	90,630	10,106		100,736		100,736		100,736			11
12	Social Services	119,835		1,145	120,980		120,980		120,980			12
13	CNA Training											13
14	Program Transportation			4,988	4,988		4,988		4,988			14
15	Other (specify):*							7,812	7,812			15
16	TOTAL Health Care and Programs	2,155,058	261,746	1,476,300	3,893,104		3,893,104	20,024	3,913,128			16
	C. General Administration											
17	Administrative	116,532			116,532		116,532	93,288	209,820			17
18	Directors Fees											18
19	Professional Services			233,452	233,452	(205)	233,247	(86,753)	146,494			19
20	Dues, Fees, Subscriptions & Promotions			101,700	101,700		101,700	(28,271)	73,429			20
21	Clerical & General Office Expenses	84,273	26,366	579,692	690,331		690,331	(388,325)	302,006			21
22	Employee Benefits & Payroll Taxes			435,074	435,074		435,074	(176)	434,898			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,048	1,048		1,048	240	1,288			24
25	Other Admin. Staff Transportation			1,060	1,060		1,060	4,308	5,368			25
26	Insurance-Prop.Liab.Malpractice			175,402	175,402		175,402	8,843	184,245			26
27	Other (specify):*							32,765	32,765			27
28	TOTAL General Administration	200,805	26,366	1,527,428	1,754,599	(205)	1,754,394	(364,081)	1,390,313			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,934,663	717,983	3,339,167	6,991,813	(205)	6,991,608	(340,066)	6,651,542			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 Rock Island #0049866 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			40,126	40,126		40,126	195,362	235,488			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			319,994	319,994		319,994	(168,035)	151,959			32
33	Real Estate Taxes					205	205	131,188	131,393			33
34	Rent-Facility & Grounds			486,000	486,000		486,000	(486,000)				34
35	Rent-Equipment & Vehicles			2,339	2,339		2,339	3,148	5,487			35
36	Other (specify):*							20,939	20,939			36
37	TOTAL Ownership			848,459	848,459	205	848,664	(303,397)	545,267			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		152,708	810,535	963,243		963,243	(7,819)	955,424			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			19,102	19,102		19,102	(18,544)	558			41
42	Provider Participation Fee			274,504	274,504		274,504		274,504			42
43	Other (specify):*			11,449	11,449		11,449	(11,449)				43
44	TOTAL Special Cost Centers		152,708	1,115,590	1,268,298		1,268,298	(37,812)	1,230,486			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,934,663	870,691	5,303,216	9,108,570		9,108,570	(681,276)	8,427,294			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 Rock Island # 0049866 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 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	(16,688)	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	18,737	30		9
10	Interest and Other Investment Income	(2,829)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(98)	02		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	(524,915)	21		24
25	Fund Raising, Advertising and Promotional	(9,455)	20		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	(424,224)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (959,472)		$	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)	278,196		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 278,196		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (681,276)		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 Rock Island

ID# 0049866
Report Period Beginning: 01/01/20
Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sequestration	$ (6,040)	21	1
2	Legal Fees - Collections	(7,103)	21	2
3	Office Expense - Bank Fees	(11,505)	21	3
4	Office Exp - Credit Card Fees	(678)	21	4
5	Non-Allowable Interest	(316,400)	32	5
6	Vending & Café Income	(18,544)	41	6
7	Bldg Co - Professional Fees	(11,900)	19	7
8	Bldg Co - Amortization	(2,582)	36	8
9	Bldg Co - Fees	(77)	21	9
10	Prior Period Dues	(14,427)	20	10
11	Prior Period Medical Supplies	(8,099)	10	11
12	Additional R&M	984	06	12
13	Capitalized R&M	(3,432)	06	13
14	Public Relations	(9,438)	43	14
15	Website	(2,011)	43	15
16	Non Allowable Legal	(6,700)	19	16
17	Annual Report	(77)	20	17
18	PAC Dues	(6,195)	20	18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
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	**Total**	(424,224)		49

Detail lines 29 and 35 of Page 5 starting in C12. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 5B**

Generations at Rock Island

ID# 0049866

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Generations at Rock Island # 0049866 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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary				3,967		(604)						3,363	1
2	Food Purchase	(98)		(1,792)									(1,890)	2
3	Housekeeping						(3,684)						(3,684)	3
4	Laundry						(1,334)						(1,334)	4
5	Heat and Other Utilities	(16,688)			1,066								(15,622)	5
6	Maintenance	(2,448)	13,140	8,724	1,071		(83)						20,404	6
7	Other (specify):*			1,100	1,654								2,754	7
8	**TOTAL General Services**	(19,234)	13,140	8,032	7,758		(5,705)						3,991	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(8,099)		41,861		(2,406)	(18,391)						12,964	10
10a	Therapy						(753)						(753)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			7,812									7,812	15
16	**TOTAL Health Care and Programs**	(8,099)		49,673		(2,406)	(19,144)						20,024	16
	C. General Administration													
17	Administrative			13,282	80,006								93,288	17
18	Directors Fees													18
19	Professional Services	(18,600)	11,900	(88,297)	8,244								(86,753)	19
20	Fees, Subscriptions & Promotions	(30,154)		1,883									(28,271)	20
21	Clerical & General Office Expenses	(550,318)	77	161,914	67	(65)							(388,325)	21
22	Employee Benefits & Payroll Taxes					(176)							(176)	22
23	Inservice Training & Education													23
24	Travel and Seminar			240									240	24
25	Other Admin. Staff Transportation			4,308									4,308	25
26	Insurance-Prop.Liab.Malpractice		7,474	1,239	130								8,843	26
27	Other (specify):*			14,215	18,550								32,765	27
28	**TOTAL General Administration**	(599,072)	19,451	108,784	106,997	(241)							(364,081)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(626,405)	32,591	166,489	114,755	(2,647)	(24,849)						(340,066)	29

Facility Name & ID Number Generations at Rock Island # 0049866 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	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	18,737	173,906		2,719								195,362	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(319,229)	150,286	(1,064)	1,972								(168,035)	32
33	Real Estate Taxes		126,460		4,728								131,188	33
34	Rent-Facility & Grounds		(486,000)										(486,000)	34
35	Rent-Equipment & Vehicles			3,148									3,148	35
36	Other (specify):*	(2,582)	23,521										20,939	36
37	**TOTAL Ownership**	(303,074)	(11,826)	2,084	9,419								(303,397)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(7,819)							(7,819)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops	(18,544)											(18,544)	41
42	Provider Participation Fee													42
43	Other (specify):*	(11,449)											(11,449)	43
44	**TOTAL Special Cost Centers**	(29,993)				(7,819)							(37,812)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(959,472)	20,764	168,573	124,174	(10,467)	(24,849)						(681,276)	45

Facility Name & ID Number Generations at Rock Island # 0049866 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	$ 486,000	Rock Island Real Estate, LLC		$	$ (486,000)	1
2	V	30	Depreciation		Rock Island Real Estate, LLC		173,906	173,906	2
3	V	21	Fees		Rock Island Real Estate, LLC		77	77	3
4	V	26	Property Insurance		Rock Island Real Estate, LLC		7,474	7,474	4
5	V	32	Interest	58	Rock Island Real Estate, LLC		150,344	150,286	5
6	V	36	Mortgage insurance		Rock Island Real Estate, LLC		20,939	20,939	6
7	V	19	Professional Fees		Rock Island Real Estate, LLC		11,900	11,900	7
8	V	33	Real Estate Taxes		Rock Island Real Estate, LLC		126,460	126,460	8
9	V	06	Repairs		Rock Island Real Estate, LLC		13,140	13,140	9
10	V	36	Amortization - HUD fees		Rock Island Real Estate, LLC		2,582	2,582	10
11	V								11
12	V								12
13	V								13
14	Total			$ 486,058			$ 506,822	$ * 20,764	14

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

STATE OF ILLINOIS

Page 6-Supplemental

Facility Name & ID Number Generations at Rock Island # 0049866 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	28.44%	ALBANY CARE, INC.	EVANSTON	ROCK ISLAND REAL ESTATE, I	lincolnwood	BUILDING CO.	1
2	Barrish Bryan G. Trust 09/01/04	9.48%	AUBURN VILLAGE	AUBURN, IN	GENERATIONS HEALTH NETW	LINCOLNWOOD	CONSULTING CO.	2
3	Barris Group Limited Partnership	9.48%	BRYN MAWR CARE INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	United Trust #1	4.74%	DECATUR MANOR HEALTHCARE,LLC	DECATUR	OAKTON ARMS	DES PLAINES	ASSISTED LIVING	4
5	United Trust #2	4.74%	GENERATIONS AT APPLEWOOD, LLC	MATTESON	MAC Rx LLC	DES PLAINES	PHARMACY	5
6	Ralph Gesualdo Childrens Trust	9.48%	GENERATIONS AT ELMWOOD PARK, INC	ELMWOOD PARK	BIG TEN SUPPLY, LLC	LIBERTYVILLE	SUPPLY CO.	6
7	Ralph Gesaldo	9.48%	GENERATIONS AT LINCOLN, LLC	LINCOLN	TRANSITIONS INDIANA	HUNTLEY	HOSPICE	7
8	Bergthold Louise	1.13%	GENERATIONS AT NEIGHBORS, LLC	BYRON	GENERATIONS AT RIVERVIEW		ASSISTED & INDEPENDENT	8
9	Chin Fay	1.13%	GENERATIONS AT OAKTON PAVILION, LLC	DES PLAINES	SENIOR LIVING	EAST PEORIA	LIVING	9
10	Lynn Ethell	1.13%	GENERATIONS AT PEORIA, LLC	PEORIA				10
11	Guzman, Nenita	1.13%	GENERATIONS AT REGENCY, LLC	NILES				11
12	McDiarmid Patricia	1.13%	GENERATIONS AT RIVERVIEW, LLC	EAST PEORIA				12
13	Nunziato Ron	1.13%	GREENWOOD CARE, INC.	EVANSTON				13
14	Oravec Jeff	1.13%	PRAIRIE CREEK VILLAGE, LLC	DECATUR				14
15	Shelton Kim	1.13%	VILLA CLARA POST ACUTE, LLC	DECATUR				15
16	Thomas & Stephanie Winter Revocable Trust	5.65%	WILSON CARE, INC.	CHICAGO				16
17	B.G. Trust	4.74%						17
18	L.G. Trust	4.74%						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 Rock Island # 0049866 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								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Generations at Rock Island # 0049866 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Dietary Other and Rebates	$	Generations HC Network, LLC		$ (1,792)	$ (1,792)	15
16	V	6	Repairs & Maintanence		Generations HC Network, LLC		8,724	8,724	16
17	V	7	Emp. Ben. - General Svc.		Generations HC Network, LLC		1,100	1,100	17
18	V	9	Medical Director Consults		Generations HC Network, LLC				18
19	V	10	Nursing		Generations HC Network, LLC		41,861	41,861	19
20	V	15	Emp. Ben. - Health Care		Generations HC Network, LLC		7,812	7,812	20
21	V	17	Administrative		Generations HC Network, LLC		13,282	13,282	21
22	V	19	Professional Fees	93,600	Generations HC Network, LLC		5,303	(88,297)	22
23	V	20	Fee, Subscriptions		Generations HC Network, LLC		1,883	1,883	23
24	V	21	Clerical & General		Generations HC Network, LLC		161,914	161,914	24
25	V	24	Education & Seminar		Generations HC Network, LLC		240	240	25
26	V	25	Other Admin. Staff Transportation		Generations HC Network, LLC		4,308	4,308	26
27	V	26	Insurance		Generations HC Network, LLC		1,239	1,239	27
28	V	27	Emp. Ben. - Gen. Admin.		Generations HC Network, LLC		14,215	14,215	28
29	V	32	Interest		Generations HC Network, LLC		(1,064)	(1,064)	29
30	V	35	Auto Rental		Generations HC Network, LLC		2,675	2,675	30
31	V	35	Equipment Rental		Generations HC Network, LLC		473	473	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 93,600			$ 262,173	$ * 168,573	39

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

Facility Name & ID Number Generations at Rock Island # 0049866 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary Salaries	$	Generations HC Network, LLC		$ 3,967	$ 3,967	15
16	V	7	Emp. Ben. - Dietary		Generations HC Network, LLC		742	742	16
17	V	17	Admin./Legal Salaries		Generations HC Network, LLC		80,006	80,006	17
18	V	19	Fin. Consult./Regl. Dir.		Generations HC Network, LLC		7,984	7,984	18
19	V	27	Emp. Ben. - Administrative		Generations HC Network, LLC		18,550	18,550	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V	6	Maintenance Salaries	4,545	Generations HC Network, LLC		4,697	152	25
26	V	7	Employee Benefits		Generations HC Network, LLC		912	912	26
27	V								27
28	V	5	Utilities		Generations HC Network, LLC		1,066	1,066	28
29	V	6	Repairs & Maintenance		Generations HC Network, LLC		919	919	29
30	V	19	Professional Fees		Generations HC Network, LLC		260	260	30
31	V	21	Clerical & General		Generations HC Network, LLC		67	67	31
32	V	26	Insurance		Generations HC Network, LLC		130	130	32
33	V	30	Depreciation		Generations HC Network, LLC		2,719	2,719	33
34	V	32	Interest		Generations HC Network, LLC		1,972	1,972	34
35	V	33	Real Estate Taxes		Generations HC Network, LLC		4,728	4,728	35
36	V								36
37	V								37
38	V								38
39	Total			$ 4,545			$ 128,719	$ * 124,174	39

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

Facility Name & ID Number Generations at Rock Island # 0049866 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	$ 25,749	MAC Rx, LLC		$ 23,343	$ (2,406)	15
16	V	21	Clerical & General Office Expenses	695	MAC Rx, LLC		630	(65)	16
17	V	22	Employee Benefits	1,884	MAC Rx, LLC		1,708	(176)	17
18	V	39	Ancillary	83,667	MAC Rx, LLC		75,848	(7,819)	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			$ 111,995			$ 101,528	$ * (10,467)	39

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

Facility Name & ID Number Generations at Rock Island # 0049866 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$ 6,285	Big Ten Supply, LLC		$ 5,681	$ (604)	15
16	V	3	Housekeeping	38,328	Big Ten Supply, LLC		34,644	(3,684)	16
17	V	4	Laundry	13,877	Big Ten Supply, LLC		12,543	(1,334)	17
18	V	6	Repairs & Maintenance	866	Big Ten Supply, LLC		783	(83)	18
19	V	10	Nursing And Medical Records	191,349	Big Ten Supply, LLC		172,958	(18,391)	19
20	V	10A	Therapy	7,831	Big Ten Supply, LLC		7,078	(753)	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			$ 258,537			$ 233,688	$ * (24,849)	39

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

Facility Name & ID Number Generations at Rock Island # 0049866 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. [ ] YES [ ] NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								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			$			$	$ *	39

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

Facility Name & ID Number Generations at Rock Island # 0049866 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. [ ] YES [ ] NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								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			$			$	$ *	39

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

Facility Name & ID Number Generations at Rock Island # 0049866 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. [ ] YES [ ] NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								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			$			$	$ *	39

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

Facility Name & ID Number Generations at Rock Island # 0049866 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. ☐ 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			$			$	$	15
16	V								16
17	V								17
18	V								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			$			$	$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								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			$			$	$ *	39

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

Facility Name & ID Number Generations at Rock Island # 0049866 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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Bryan Barrish	Relative	Administrative		See Attached	1.34	3.34%	Alloc. Salary	$ 9,554	17-7	1
2	Burton Barrish	Relative	Administrative		See Attached	1.53	3.82%	Alloc. Salary	4,137	17-7	2
3	Sarah Barrish	Relative	Administrative		See Attached	1.91	3.82%	Alloc. Salary	4,912	17-7	3
4	Louise Bergthold	Shareholder	Administrative	1.13%	See Attached	2.29	3.82%	Alloc. Salary	9,554	17-7	4
5	Thomas Bergthold	Relative	Clerical		See Attached	1.53	3.82%	Alloc. Salary	2,314	21-7	5
6	Clark Collins	Relative	Administrative		See Attached	2.21	5.53%	Alloc. Salary	2,936	Var.	6
7	Lynn Ethell	Shareholder	Clerical	1.13%	See Attached	1.53	3.82%	Alloc. Salary	2,302	21-7	7
8	Nenita Guzman	Shareholder	Dietary	1.13%	See Attached	1.53	3.82%	Alloc. Salary	3,967	1-7	8
9	Jeff Oravec	Shareholder	Administrative	1.13%	See Attached	1.53	3.82%	Alloc. Salary	3,728	17-7	9
10	See Supplemental Schedule								20,876		10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 64,281		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 Rock Island # 0049866 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
Street Address
City / State / Zip Code
Phone Number ( )
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 Rock Island # 0049866 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

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

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

	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	Patient Days	832,144	19	$ (46,886)	$	31,800	$ (1,792)	1
2	6	Repairs & Maintanence	Patient Days	832,144	19	228,292	155,904	31,800	8,724	2
3	7	Emp. Ben. - General Svc.	Patient Days	832,144	19	28,781		31,800	1,100	3
4	9	Medical Director Consults	Patient Days	832,144	19			31,800		4
5	10	Nursing	Patient Days	832,144	19	1,095,433	1,094,370	31,800	41,861	5
6	15	Emp. Ben. - Health Care	Patient Days	832,144	19	204,429		31,800	7,812	6
7	17	Administrative	Patient Days	832,144	19	347,566	347,566	31,800	13,282	7
8	19	Professional Fees	Patient Days	832,144	19	138,762		31,800	5,303	8
9	20	Fee, Subscriptions	Patient Days	832,144	19	49,284		31,800	1,883	9
10	21	Clerical & General	Patient Days	832,144	19	4,236,976	3,850,828	31,800	161,914	10
11	24	Education & Seminar	Patient Days	832,144	19	6,287		31,800	240	11
12	25	Other Admin. Staff Transportatio	Patient Days	832,144	19	112,731		31,800	4,308	12
13	26	Insurance	Patient Days	832,144	19	32,419		31,800	1,239	13
14	27	Emp. Ben. - Gen. Admin.	Patient Days	832,144	19	371,977		31,800	14,215	14
15	32	Interest	Patient Days	832,144	19	(27,854)		31,800	(1,064)	15
16	35	Auto Rental	Patient Days	832,144	19	70,001		31,800	2,675	16
17	35	Equipment Rental	Patient Days	832,144	19	12,377		31,800	473	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 6,860,575	$ 5,448,668		$ 262,173	25

Facility Name & ID Number Generations at Rock Island # 0049866 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, IL. 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	832,144	19	$ 103,820	$ 103,820	31,800	$ 3,967	1
2	7	Emp. Ben. - Dietary	Patient Days	832,144	19	19,413		31,800	742	2
3	17	Admin./Legal Salaries	Patient Days	832,144	19	2,093,591	2,093,591	31,800	80,006	3
4	19	Fin. Consult./Regl. Dir.	Patient Days	832,144	19	208,920		31,800	7,984	4
5	27	Emp. Ben. - Administrative	Patient Days	832,144	19	485,424		31,800	18,550	5
6										6
7										7
8										8
9										9
10										10
11	6	Maintenance Salaries	Maintenance Income	702,930	17	726,469	726,469	4,545	4,697	11
12	7	Employee Benefits	Maintenance Income	702,930	17	141,032		4,545	912	12
13										13
14	5	Utilities	Allocated Sq. Ft.	12,879	19	27,900		492	1,066	14
15	6	Repairs & Maintenance	Allocated Sq. Ft.	12,879	19	24,049		492	919	15
16	19	Professional Fees	Allocated Sq. Ft.	12,879	19	6,801		492	260	16
17	21	Clerical & General	Allocated Sq. Ft.	12,879	19	1,754		492	67	17
18	26	Insurance	Allocated Sq. Ft.	12,879	19	3,403		492	130	18
19	30	Depreciation	Allocated Sq. Ft.	12,879	19	71,181		492	2,719	19
20	32	Interest	Allocated Sq. Ft.	12,879	19	51,631		492	1,972	20
21	33	Real Estate Taxes	Allocated Sq. Ft.	12,879	19	123,763		492	4,728	21
22										22
23										23
24										24
25	TOTALS					$ 4,089,151	$ 2,923,880		$ 128,719	25

Facility Name & ID Number Generations at Rock Island # 0049866 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

	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 And Medical Records	Direct Allocation			$	$		$ 23,343	1
2	21	Clerical & General Office Expense	Direct Allocation						630	2
3	22	Employee Benefits	Direct Allocation						1,708	3
4	39	Ancillary	Direct Allocation						75,848	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					$	$		$ 101,528	25

Facility Name & ID Number Generations at Rock Island # 0049866 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, IL 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			$	$		$ 5,681	1
2	3	Housekeeping	Direct Allocation						34,644	2
3	4	Laundry	Direct Allocation						12,543	3
4	6	Repairs & Maintenance	Direct Allocation						783	4
5	10	Nursing And Medical Records	Direct Allocation						172,958	5
6	10A	Therapy	Direct Allocation						7,078	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					$	$		$ 233,688	25

Facility Name & ID Number Generations at Rock Island # 0049866 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 [ ]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
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 Rock Island # 0049866 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 ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
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 Rock Island # 0049866 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

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

	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 Rock Island # 0049866 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 [ ]

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

	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 Rock Island # 0049866 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 ☐

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
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 Rock Island # 0049866 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**		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	Centrue Bank		X	Mortgage Payable			$	$ 4,128,140			$ 150,344	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Lake Forest Bank & Trust		X	Line of Credit							3,594	6
7												7
8												8
9	TOTAL Facility Related						$	$ 4,128,140			$ 153,938	9
	B. Non-Facility Related*											
10	Interest Income		X								(2,829)	10
11	Interest Income - Bldg Co		X								(58)	11
12	Allocated from Generations HC	X									908	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,979)	14
15	TOTALS (line 9+line14)						$	$ 4,128,140			$ 151,959	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 20,939 Line # 36

* 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 Rock Island # 0049866 **Report Period Beginning:** 01/01/20 **Ending:** 12/31/20

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2019 report.	$	121,100	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.)	$	125,488	2
3. Under or (over) accrual (line 2 minus line 1).	$	4,388	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	126,800	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.)**	$	205	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.	$	131,393	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	108,643	8
	2016	108,758	9
	2017	112,112	10
	2018	115,305	11
	2019	120,760	12

2020 Accrual = $120,760 x 1.05 = $126,800 (rounded)

Allocated from Generations Healthcare Network: $4,728

	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 Rock Island COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0049866

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: ( )

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)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	16-12-108-001	Long Term Care Property	$ 119,064.72	$ 119,064.72
2.	16-12-108-002	Long Term Care Property	$ 1,695.76	$ 1,695.76
3.	10-31-401-046-0000	Allocated from Regency	$ 796,746.36	$ 369.81
4.	See Attached	Allocated from S.I.R. Properties	$ 148,905.51	$ 4,454.94
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,066,412.35	$ 125,585.23

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2019 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Generations at Rock Island COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0049866

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A)	(B)	(C)	(D)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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? ______ 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 54,494 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 4 & Basement

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	224,770	1997	$ 420,000	1
2					2
3	TOTALS	224,770		$ 420,000	3

Facility Name & ID Number Generations at Rock Island # 0049866 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	177			1975	$ 3,579,244	$ 173,906	39	$ 91,775	$ (82,131)	$ 2,054,216	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2002	10,887		20	544	544	7,303	9
10	Various			2003	5,954		20	298	298	3,775	10
11	Various			2004	9,240		20	462	462	5,684	11
12	Various			2005	48,760		20	2,235	2,235	33,163	12
13	Various			2006	39,068		20	1,953	1,953	21,522	13
14	Various			2008	539,334		20	351	351	536,680	14
15	Various			2009	265,059		20	11,373	11,373	169,732	15
16	Various			2010	21,670		20	675	675	15,473	16
17	Various			2011	22,410		20	1,120	1,120	11,899	17
18	Various			2012	2,524		20	126	126	1,062	18
19	Various			2013	51,415		20	2,571	2,571	19,808	19
20	Various			2014	36,562		20	1,828	1,828	11,706	20
21	Various			2016	5,939		20	297	297	1,431	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Generations at Rock Island # 0049866 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			$	$		$	$	$	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
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58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		603,447			27,519	27,519	251,584	67
68	Related Party Allocations (Pages 12H & 12I)		79,619	1,523		2,403	881	49,082	68
69	Financial Statement Depreciation			40,126			(40,126)		69
70	TOTAL (lines 4 thru 69)		$ 5,321,132	$ 215,555		$ 145,531	$ (70,024)	$ 3,194,120	70

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

Facility Name & ID Number Generations at Rock Island # 0049866 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		$ 5,321,132	$ 215,555		$ 145,531	$ (70,024)	$ 3,194,120	1
2	Flooring & Wall Base - 2Nd Floor Corridors	2017	4,929		20	246	246	759	2
3	Repaired A/C	2017	2,996		20	150	150	525	3
4	Colid Cleaner Hvac	2017	2,619		20	131	131	447	4
5	Hall Remodeling Project - Wallcovering	2018	8,132		20	407	407	1,152	5
6	Replace Fire Pull Stations	2018	2,636		20	132	132	341	6
7	Fence Project	2018	7,010		20	351	351	1,023	7
8	Paint 102Ptac Units	2018	9,200		20	460	460	1,073	8
9	New Door	2018	2,648		20	132	132	309	9
10	Landscape Project - 6 New Trees	2018	16,697		20	835	835	1,948	10
11	Awnings And Frames (4)	2018	4,034		20	202	202	454	11
12	Generator Transfer Switch Control (Book)	2019	5,186		20	259	259	324	12
13	100 Gallon Water Heater	2019	7,820		20	391	391	782	13
14	Installed A/C Wall Units	2019	3,876		20	194	194	388	14
15	Installed A/C Wall Units	2019	3,018		20	151	151	302	15
16	Thru Wall Mounted A/C	2020	3,432		20	172	172	172	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,405,365	$ 215,555		$ 149,744	$ (65,811)	$ 3,204,119	34

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

Facility Name & ID Number Generations at Rock Island # 0049866 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		$ 5,405,365	$ 215,555		$ 149,744	$ (65,811)	$ 3,204,119	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)		$ 5,405,365	$ 215,555		$ 149,744	$ (65,811)	$ 3,204,119	34

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

Facility Name & ID Number Generations at Rock Island # 0049866 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		$ 5,405,365	$ 215,555		$ 149,744	$ (65,811)	$ 3,204,119	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)		$ 5,405,365	$ 215,555		$ 149,744	$ (65,811)	$ 3,204,119	34

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

Facility Name & ID Number Generations at Rock Island # 0049866 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		$ 5,405,365	$ 215,555		$ 149,744	$ (65,811)	$ 3,204,119	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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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)		$ 5,405,365	$ 215,555		$ 149,744	$ (65,811)	$ 3,204,119	34

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

Facility Name & ID Number Generations at Rock Island # 0049866 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	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Flooring, Wallcovering, Window Treatment, Doord	1997	50,964		20			50,964	9
10	Windows	1998	2,278		20	114	114	1,861	10
11	Walk in Freezer Compressor	2000	2,097		20			2,097	11
12	Electrical Work	2001	1,854		20	93	93	1,498	12
13	Water Heater	2008	6,570		20	329	329	5,263	13
14	Handrails	2008	100,904		20	5,045	5,045	80,720	14
15	Electrical Work-Resident Rooms	2010	7,985		20	399	399	3,592	15
16	Wall Removal - 4th Floor Dining	2010	7,000		20	350	350	3,535	16
17	Outdoor Fence	2010	6,570		20	329	329	2,960	17
18	Kitchen Lighting	2010	8,026		20	401	401	6,424	18
19	Flooring- Carpert and Tile	2011	7,869		20	393	393	3,145	19
20	Fire-Sprinkler Heads	2011	2,790		20	140	140	1,119	20
21	Outdoor Facility Light sign	2012	10,113		20	506	506	3,541	21
22	Compressor for Walk in Freezer	2012	5,820		20	291	291	2,037	22
23	Dialysis Room- New: Construction, plumbing, HVAC & Electrical	2012	42,518		20	2,126	2,126	14,882	23
24	Nurse Call System	2012	7,800		20	390	390	2,730	24
25	Installed Amtico Flooring on 1st Floor Therapy Room	2013	9,999		20	500	500	3,000	25
26	Installed Cabintery, Countertop Finish & Molding in Physical	2013	12,400		20	620	620	3,720	26
27	Installed Nurse Station	2013	25,000		20	1,250	1,250	7,500	27
28	Installed Elevator Panel	2013	8,000		20	400	400	2,400	28
29	Installed Cabintery	2013	5,000		20	250	250	1,500	29
30	Replacment Windows	2013	9,133		20	457	457	2,740	30
31	Install Flooring & Walls in Break Room & Adjoining Bathroom	2014	4,330		20	217	217	1,081	31
32	Kitchen Floor Tile	2015	17,653		20	883	883	4,414	32
33	Asphalt & Concrete Work	2015	69,600		20	3,480	3,480	17,400	33
34	TOTAL (lines 1 thru 33)		$ 432,273	$		$ 18,961	$ 18,961	$ 230,123	34

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

Facility Name & ID Number Generations at Rock Island # 0049866 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		$ 432,273	$		$ 18,961	$ 18,961	$ 230,123	1
2	Wall-guards in Hallways	2017	7,541		20	377	377	1,131	2
3	Installed New Hydrant	2017	5,845		20	292	292	877	3
4	Install new car Sills-Elevator	2017	6,214		20	311	311	932	4
5	Landscaping work, new plants	2017	5,551		20	278	278	833	5
6	Concrete removal & repaving	2017	56,086		20	2,804	2,804	8,413	6
7	Wall A/C 3 & scale	2017	2,975		20	149	149	446	7
8	Replace Handrails/Corner Guards Throughout Facility, As Neede	2017	2,648		20	132	132	397	8
9	Wifi System Upgrade	2018	10,464		20	523	523	1,046	9
10	Water Heaters	2018	11,500		20	575	575	1,150	10
11	Cabinets in Therapy Room	2018	14,800		20	740	740	1,480	11
12	Bath Tile Work	2018	14,061		20	703	703	1,406	12
13	Painted Therapy Room Walls and Ceiling	2018	23,114		20	1,156	1,156	2,311	13
14	Thru-Wall AC	2019	3,876		20	194	194	388	14
15	Cabinets And Quartz Tops	2019	6,500		20	325	325	650	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 603,447	$		$ 27,519	$ 27,519	$ 251,584	34

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

Facility Name & ID Number Generations at Rock Island # 0049866 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	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Generations Healthcare Network, LLC	2009	19,101	510	39	490	(20)	5,408	3
4	Allocated from S.I.R. Properties/GHN	1993	17,293	549	35	494	(55)	13,093	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Generations Healthcare Network, LLC	1993	4,384	122	20		(122)	4,384	9
10	Allocated from Generations Healthcare Network, LLC	1994	14		20			14	10
11	Allocated from Generations Healthcare Network, LLC	1995	100		20			100	11
12	Allocated from Generations Healthcare Network, LLC	1997	6,737	151	20		(151)	6,737	12
13	Allocated from Generations Healthcare Network, LLC	1999	530		20	20	20	530	13
14	Allocated from Generations Healthcare Network, LLC	1999							14
15	Allocated from Generations Healthcare Network, LLC	2000	625		20	14	14	625	15
16	Allocated from Generations Healthcare Network, LLC	2007	2,009		20	100	100	1,326	16
17	Allocated from Generations Healthcare Network, LLC	2008	5,538		20	205	205	4,050	17
18	Allocated from Generations Healthcare Network, LLC	2009	13,761		20	688	688	7,736	18
19	Allocated from Generations Healthcare Network, LLC	2011	340	34	20	34		321	19
20	Allocated from Generations Healthcare Network, LLC	2012	1,089	54	20	54		404	20
21	Allocated from Generations Healthcare Network, LLC	2014	153	15	20	8	(8)	50	21
22	Allocated from Generations Healthcare Network, LLC	2016	199	10	20	10		44	22
23	Allocated from Generations Healthcare Network, LLC	2019	991	49	20	49		62	23
24	Allocated from Generations Healthcare Network, LLC	2020	807	17	20	17	0	17	24
25									25
26	Allocated from S.I.R. Properties/GHN	2012	1,059		20	53	53	371	26
27	Allocated from S.I.R. Properties/GHN	2010	1,044		20	52	52	487	27
28	Allocated from S.I.R. Properties/GHN	2009	1,038		20	52	52	561	28
29	Allocated from S.I.R. Properties/GHN	2007	102	6	20	5	(1)	67	29
30	Allocated from S.I.R. Properties/GHN	2002	69		20	3	3	60	30
31	Allocated from S.I.R. Properties/GHN	1999	2,191		20	55	55	2,191	31
32	Allocated from S.I.R. Properties/GHN	1994	165	4	20		(4)	165	32
33	Allocated from S.I.R. Properties/GHN	1993	280	1	20		(1)	280	33
34	TOTAL (lines 1 thru 33)		$ 79,619	$ 1,523		$ 2,403	$ 881	$ 49,082	34

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

Facility Name & ID Number Generations at Rock Island # 0049866 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		$ 79,619	$ 1,523		$ 2,403	$ 881	$ 49,082	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
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 79,619	$ 1,523		$ 2,403	$ 881	$ 49,082	34

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

Facility Name & ID Number Generations at Rock Island # 0049866 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	$ 835,459	$ 810	$ 83,555	$ 82,745	10	$ 763,619	71
72	Current Year Purchases	15,145	11	1,509	1,498	10	1,509	72
73	Fully Depreciated Assets	622,186				10	622,186	73
74								74
75	TOTALS	$ 1,472,790	$ 821	$ 85,065	$ 84,244		$ 1,387,314	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79		See Attached		4,505	376	680	304		2,414	79
80	TOTALS			$ 4,505	$ 376	$ 680	$ 304		$ 2,414	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)	$ 7,302,659	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 216,752	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 235,488	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 18,737	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,593,847	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	Nurse Call System	$ 18,422	92
93			93
94			94
95		$ 18,422	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 Rock Island # 0049866 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: $ 2,812 Description: See Attached
    (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 HC		$	$ 2,675	17
18					18
19					19
20					20
21	TOTAL		$	$ 2,675	21

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

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

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

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

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.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 308,090	$		$ 308,090	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			51,295			51,295	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			302,030			302,030	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				80,651		80,651	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached					149,120	72,057		221,177	13
14	TOTAL			$		$ 810,535	$ 152,708		$ 963,243	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 Rock Island # 0049866 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	$ 1,205,913	$ 1,304,753	1
2	Cash-Patient Deposits	80,981	80,981	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	727,567	727,567	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	41,757	42,388	6
7	Other Prepaid Expenses	962,587	962,587	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	556	223,473	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,019,361	$ 3,341,749	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		420,000	13
14	Buildings, at Historical Cost		3,483,607	14
15	Leasehold Improvements, at Historical Cost	862,380	1,548,345	15
16	Equipment, at Historical Cost	636,044	1,451,501	16
17	Accumulated Depreciation (book methods)	(1,160,829)	(3,071,748)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		25,719	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(25,719)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached	35,913	1,072,442	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 373,508	$ 4,904,147	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,392,869	$ 8,245,896	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 642,758	$ 642,758	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	81,015	81,015	28
29	Short-Term Notes Payable		134,176	29
30	Accrued Salaries Payable	84,477	84,477	30
31	Accrued Taxes Payable (excluding real estate taxes)	140,636	140,636	31
32	Accrued Real Estate Taxes(Sch.IX-B)		126,800	32
33	Accrued Interest Payable		12,350	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	2,646,514	2,647,679	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,595,400	$ 3,869,891	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,993,965	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	6,950,000	6,950,000	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 6,950,000	$ 10,943,965	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 10,545,400	$ 14,813,856	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (7,152,531)	$ (6,567,960)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,392,869	$ 8,245,896	48

*(See instructions.)

Facility Name & ID Number Generations at Rock Island # 0049866 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**	$ (5,533,504)	1
2	Restatements (describe):		2
3	Rounding	9	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (5,533,495)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,619,036)	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)**	$ (1,619,036)	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)**	$ (7,152,531)	24 *

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

Facility Name & ID Number Generations at Rock Island # 0049866 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	$ 6,039,216	1
2	Discounts and Allowances for all Levels	(1,278,075)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,761,141	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,621,570	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,621,570	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	85,677	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,359	19
20	Radiology and X-Ray	2,948	20
21	Other Medical Services	29,748	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 121,732	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,829	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,829	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Attached	982,262	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 982,262	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,489,534	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,344,110	31
32	Health Care	3,893,104	32
33	General Administration	1,754,599	33
	B. Capital Expense		
34	Ownership	848,459	34
	C. Ancillary Expense		
35	Special Cost Centers	993,794	35
36	Provider Participation Fee	274,504	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,108,570	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,619,036)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,619,036)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,434,536	44
45	Private Pay - Net Inpatient Revenue	167,555	45
46	Medicare - Net Inpatient Revenue	826,213	46
47	Other-(specify) Managed Care, Insurance	2,142,750	47
48	Other-(specify) Hospice	190,087	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,761,141	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 Rock Island # 0049866 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	818	903	$ 44,485	$ 49.26	1
2	Assistant Director of Nursing	2,136	2,239	82,576	36.88	2
3	Registered Nurses	7,649	8,122	303,851	37.41	3
4	Licensed Practical Nurses	15,949	16,896	526,036	31.13	4
5	CNAs & Orderlies	47,064	49,446	835,830	16.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,178	4,667	78,901	16.91	8
9	Activity Director					9
10	Activity Assistants	5,524	6,213	90,630	14.59	10
11	Social Service Workers	5,876	6,433	119,835	18.63	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,232	25,136	321,944	12.81	15
16	Dishwashers					16
17	Maintenance Workers	3,366	3,534	82,979	23.48	17
18	Housekeepers	9,801	10,498	128,779	12.27	18
19	Laundry	3,933	4,133	45,098	10.91	19
20	Administrator	1,880	2,065	116,532	56.43	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,511	4,895	84,273	17.22	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	1,933	2,048	72,914	35.60	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	138,850	147,228	$ 2,934,663 *	$ 19.93	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	$ 20,463	01-03	35
36	Medical Director	Monthly	60,500	09-03	36
37	Medical Records Consultant	Monthly	5,630	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,934	10-03	39
40	Physical Therapy Consultant	Monthly	11,425	10a-03	40
41	Occupational Therapy Consultant	Monthly	11,419	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly	4,165	10a-03	43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	1,145	12-03	45
46	Other(specify) Chief Medical Officer	Monthly	49,140	10-03	46
47	Restorative Nursing	Monthly	660	10-03	47
48					48
49	TOTAL (lines 35 - 48)		$ 171,481		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	12,672	$ 755,710	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	13,316	564,584	10-03	52
53	TOTAL (lines 50 - 52)	25,988	$ 1,320,294		53

Facility Name & ID Number: Generations at Rock Island # 0049866 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Adra M Baldwin	Administrator	0	$ 116,532
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 116,532

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 Healthcare Network	Bookkeeping	$ 93,600
Generations Healthcare Network	Computer Support	36,960
Marcum LLP	Accounting	16,200
Plante Moran	Accounting	4,940
Personnel Planners	Unemployment Consultant	3,843
Achieve Accreditation	Accreditation	9,224
iSolved HCM Midwest, LLC	Tax Consultant	2,988
Pinnacle	Customer Satisfaction	2,487
Paychex	Payroll	527
Paylocity	Data Processing	10,289
See Attached	Legal	18,327
See Supplemental Schedule		34,068
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 233,451

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 64,278
Unemployment Compensation Insurance	29,323
FICA Taxes	224,502
Employee Health Insurance	107,274
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	364
Other Employee Benefits	7,625
Covid 19 Employee Benefits	1,708
Allocated from MAC Rx	(176)
TOTAL (agree to Schedule V, line 22, col.8)	$ 434,898

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	45,662
Health Care Worker Background Check (Indicate # of checks performed 572)	5,727
Patient Background Checks	
Dues & Subscriptions	6,838
Licenses & Fees	11,327
See Supplemental Schedule	1,883
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 73,429

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,048
See Supplemental Schedule	240
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,288

**See instructions.

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. **HCCI $12,390**

(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. $ **44,546** Line **10**

(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? **X** YES ____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO ____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
River Park Healthcare Center #0042549

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **274,504**
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? **N/A** Indicate the amount. $ ____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **No**
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.