

Facility Name & ID Number Generations at Rock Island

0049866 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	64,605	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	64,605	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	25,526	1,120	8,070	34,716	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,526	1,120	8,070	34,716	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 53.74%

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

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

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 Date 03/06/1997 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 177 and days of care provided 3,750

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Generations at Rock Island # 0049866 Report Period Beginning: 01/01/17 Ending: 12/31/17

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	203,837	34,261	44,400	282,498		282,498	(18,975)	263,523		1
2	Food Purchase		260,799		260,799	(23,199)	237,600	(748)	236,852		2
3	Housekeeping	168,183	48,374		216,557		216,557	(3,679)	212,878		3
4	Laundry	86,747	32,918		119,665		119,665	(677)	118,988		4
5	Heat and Other Utilities			231,160	231,160		231,160	(19,709)	211,451		5
6	Maintenance	59,168	45,725	176,248	281,141		281,141	(16,307)	264,834		6
7	Other (specify):*							8,333	8,333		7
8	TOTAL General Services	517,935	422,077	451,808	1,391,820	(23,199)	1,368,621	(51,761)	1,316,859		8
	B. Health Care and Programs										
9	Medical Director			66,000	66,000		66,000	4,102	70,102		9
10	Nursing and Medical Records	1,905,949	184,378	896,735	2,987,062		2,987,062	(30,975)	2,956,087		10
10a	Therapy	128,750	(98)	22,667	151,319		151,319	(12,634)	138,685		10a
11	Activities	108,102	11,690		119,792		119,792		119,792		11
12	Social Services	224,630		1,955	226,585		226,585		226,585		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							6,256	6,256		15
16	TOTAL Health Care and Programs	2,367,431	195,970	987,357	3,550,758		3,550,758	(33,250)	3,517,508		16
	C. General Administration										
17	Administrative	96,518		95,592	192,110		192,110	(7,531)	184,579		17
18	Directors Fees										18
19	Professional Services			335,788	335,788		335,788	(203,136)	132,652		19
20	Dues, Fees, Subscriptions & Promotions			67,757	67,757		67,757	(23,270)	44,487		20
21	Clerical & General Office Expenses	154,513	26,152	129,709	310,374		310,374	(15,667)	294,707		21
22	Employee Benefits & Payroll Taxes			490,536	490,536	23,199	513,735	(167)	513,568		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,194	6,194		6,194	115	6,309		24
25	Other Admin. Staff Transportation			7,114	7,114		7,114	7,012	14,126		25
26	Insurance-Prop.Liab.Malpractice			166,050	166,050		166,050	7,320	173,370		26
27	Other (specify):*							26,649	26,649		27
28	TOTAL General Administration	251,031	26,152	1,298,740	1,575,923	23,199	1,599,122	(208,675)	1,390,448		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,136,397	644,199	2,737,905	6,518,501		6,518,501	(293,686)	6,224,815		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:

01/01/17

Ending:

12/31/17

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			114,560	114,560		114,560	174,756	289,316			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			91,131	91,131		91,131	119,829	210,960			32
33	Real Estate Taxes							114,620	114,620			33
34	Rent-Facility & Grounds			480,000	480,000		480,000	(480,000)				34
35	Rent-Equipment & Vehicles			2,735	2,735		2,735	3,162	5,897			35
36	Other (specify):*							22,783	22,783			36
37	TOTAL Ownership			688,426	688,426		688,426	(44,850)	643,576			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	258,958	339,736	558,162	1,156,856		1,156,856	(15,066)	1,141,790			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			290,311	290,311		290,311		290,311			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	258,958	339,736	848,473	1,447,167		1,447,167	(15,066)	1,432,101			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,395,355	983,935	4,274,804	8,654,094		8,654,094	(353,601)	8,300,493			45

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

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(664)	02		4
5	Telephone, TV & Radio in Resident Rooms	(20,997)	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	(31,736)	30		9
10	Interest and Other Investment Income	(1,794)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(84)	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	(73,573)	21		24
25	Fund Raising, Advertising and Promotional	(12,706)	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	(107,645)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (249,199)		\$	30

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	2	
		Amount	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)	(104,402)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (104,402)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (353,601)		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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY							
48		49		50		51	52

Generations at Rock Island

ID# 0049866

Report Period Beginning: 01/01/17

Ending: 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Fees	\$ (7,326)	21	1
2	Non Allowable Interest	(42,250)	32	2
3	Capitalized R&M	(5,615)	06	3
4	Non Allowable Legal	(15,789)	19	4
5	PAC Dues	(10,754)	20	5
6	Building Co. Fees	(250)	20	6
7	Bldg Co. Prof Fees	(8,900)	19	7
8	Bldg Co. Amort	(2,582)	36	8
9	Building Co. Capitalized R&M	(13,164)	06	9
10	Settlement Fees	(1,000)	21	10
11	Jury Duty	(15)	10	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
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	(107,645)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Generations at Rock Island# 0049866 Report Period Beginning:

01/01/17

Ending:

12/31/17

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				(16,679)		(2,296)						(18,975)	1
2	Food Purchase	(748)											(748)	2
3	Housekeeping						(3,679)						(3,679)	3
4	Laundry						(677)						(677)	4
5	Heat and Other Utilities	(20,997)			1,288								(19,709)	5
6	Maintenance	(18,779)	17,926	(17,127)	1,733		(60)						(16,307)	6
7	Other (specify):*			831	7,502								8,333	7
8	TOTAL General Services	(40,524)	17,926	(16,296)	(6,156)		(6,711)						(51,761)	8
	B. Health Care and Programs													
9	Medical Director			4,102									4,102	9
10	Nursing and Medical Records	(15)		(26,806)	5,374	(1,252)	(8,275)						(30,975)	10
10a	Therapy				(7,925)		(4,709)						(12,634)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			3,676	2,580								6,256	15
16	TOTAL Health Care and Programs	(15)		(19,028)	30	(1,252)	(12,985)						(33,250)	16
	C. General Administration													
17	Administrative			(78,628)	71,097								(7,531)	17
18	Directors Fees													18
19	Professional Services	(24,689)	8,900	(197,409)	10,062								(203,136)	19
20	Fees, Subscriptions & Promotions	(23,710)	250	190									(23,270)	20
21	Clerical & General Office Expenses	(81,899)		66,188	103	(30)	(28)						(15,667)	21
22	Employee Benefits & Payroll Taxes					(167)							(167)	22
23	Inservice Training & Education													23
24	Travel and Seminar			115									115	24
25	Other Admin. Staff Transportation			7,012									7,012	25
26	Insurance-Prop.Liab.Malpractice		6,016	1,170	134								7,320	26
27	Other (specify):*			9,137	17,512								26,649	27
28	TOTAL General Administration	(130,298)	15,166	(192,225)	98,908	(198)	(28)						(208,675)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(170,837)	33,092	(227,549)	92,782	(1,450)	(19,724)						(293,686)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Generations at Rock Island # 0049866 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(31,736)	201,946		4,546								174,756	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(44,044)	162,928	(2,844)	3,789								119,829	32
33	Real Estate Taxes		108,958		5,662								114,620	33
34	Rent-Facility & Grounds		(480,000)										(480,000)	34
35	Rent-Equipment & Vehicles			3,162									3,162	35
36	Other (specify):*	(2,582)	25,365										22,783	36
37	TOTAL Ownership	(78,362)	19,197	318	13,997								(44,850)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(15,066)							(15,066)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers					(15,066)							(15,066)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(249,199)	52,289	(227,231)	106,779	(16,515)	(19,724)						(353,601)	45

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 6 Supplemental		See 6 Supplemental		See 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. 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)	
1	V	34 Rental Income	\$ 480,000	Rock Island Real Estate, LLC		\$	(480,000)	1
2	V	20 Fees		Rock Island Real Estate, LLC		250	250	2
3	V	32 Interest Expense & Income	654	Rock Island Real Estate, LLC		163,582	162,928	3
4	V	36 Mortgage Insurance		Rock Island Real Estate, LLC		22,783	22,783	4
5	V	19 Professional Fees		Rock Island Real Estate, LLC		8,900	8,900	5
6	V	26 Property Insurance		Rock Island Real Estate, LLC		6,016	6,016	6
7	V	33 Real Estate Tax	5,242	Rock Island Real Estate, LLC		114,200	108,958	7
8	V	36 Amort-HUD Fees		Rock Island Real Estate, LLC		2,582	2,582	8
9	V	30 Depreciation		Rock Island Real Estate, LLC		201,946	201,946	9
10	V	06 Repairs		Rock Island Real Estate, LLC		17,926	17,926	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 485,896			\$ 538,185	\$ * 52,289	14

* 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	6 REPAIRS AND MAINT.	\$ 26,016	GENERATIONS HC NETWORK, LLC	100.00%	\$ 8,889	\$ (17,127)
16	V	7 EMP. BEN.-GEN. SERV.		GENERATIONS HC NETWORK, LLC	100.00%	831	831
17	V	9 MEDICAL DIRECTOR CONSULTS		GENERATIONS HC NETWORK, LLC	100.00%	4,102	4,102
18	V	10 NURSING	56,292	GENERATIONS HC NETWORK, LLC	100.00%	29,486	(26,806)
19	V	15 EMP. BEN.-H.C.		GENERATIONS HC NETWORK, LLC	100.00%	3,676	3,676
20	V	17 ADMINISTRATIVE	95,592	GENERATIONS HC NETWORK, LLC	100.00%	16,964	(78,628)
21	V	19 PROFESSIONAL FEES	198,480	GENERATIONS HC NETWORK, LLC	100.00%	1,071	(197,409)
22	V	20 FEES,SUBSCRIPTIONS		GENERATIONS HC NETWORK, LLC	100.00%	190	190
23	V	21 CLERICAL & GENERAL	26,016	GENERATIONS HC NETWORK, LLC	100.00%	92,204	66,188
24	V	24 EDUCATION & SEMINAR		GENERATIONS HC NETWORK, LLC	100.00%	115	115
25	V	25 OTHER ADMIN. STAFF TRANS.		GENERATIONS HC NETWORK, LLC	100.00%	7,012	7,012
26	V	26 INSURANCE		GENERATIONS HC NETWORK, LLC	100.00%	1,170	1,170
27	V	27 EMP. BEN.-GEN. ADMIN.		GENERATIONS HC NETWORK, LLC	100.00%	9,137	9,137
28	V	32 INTEREST		GENERATIONS HC NETWORK, LLC	100.00%	(2,844)	(2,844)
29	V	35 AUTO RENTAL		GENERATIONS HC NETWORK, LLC	100.00%	2,593	2,593
30	V	35 EQUIPMENT RENTAL		GENERATIONS HC NETWORK, LLC	100.00%	569	569
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 402,396			\$ 175,165	\$ * (227,231)

* 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	1	DIETARY SALARIES	\$ 21,660	GENERATIONS HC NETWORK, LLC	100.00%	\$ 4,981	\$ (16,679)	15
16	V	7	EMP. BEN.-DIETARY		GENERATIONS HC NETWORK, LLC	100.00%	863	863	16
17	V	10	NURSING SALARIES		GENERATIONS HC NETWORK, LLC	100.00%	5,374	5,374	17
18	V	15	EMP. BEN.-NURSING		GENERATIONS HC NETWORK, LLC	100.00%	928	928	18
19	V	17	ADMIN./LEGAL SALARIES		GENERATIONS HC NETWORK, LLC	100.00%	71,097	71,097	19
20	V	19	FIN. CONSULT./REGL. DIR.		GENERATIONS HC NETWORK, LLC	100.00%	10,005	10,005	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		GENERATIONS HC NETWORK, LLC	100.00%	17,512	17,512	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	17,412	GENERATIONS HC NETWORK, LLC	100.00%	9,487	(7,925)	24
25	V	15	EMPLOYEE BENEFITS		GENERATIONS HC NETWORK, LLC	100.00%	1,652	1,652	25
26	V								26
27	V	6	MAINTENANCE SALARIES	35,627	GENERATIONS HC NETWORK, LLC	100.00%	36,553	926	27
28	V	7	EMPLOYEE BENEFITS		GENERATIONS HC NETWORK, LLC	100.00%	6,639	6,639	28
29	V								29
30	V	5	UTILITIES		GENERATIONS HC NETWORK, LLC	100.00%	1,288	1,288	30
31	V	6	REPAIRS AND MAINT.		GENERATIONS HC NETWORK, LLC	100.00%	807	807	31
32	V	19	PROFESSIONAL FEES		GENERATIONS HC NETWORK, LLC	100.00%	57	57	32
33	V	21	CLERICAL & GENERAL		GENERATIONS HC NETWORK, LLC	100.00%	103	103	33
34	V	26	INSURANCE		GENERATIONS HC NETWORK, LLC	100.00%	134	134	34
35	V	30	DEPRECIATION		GENERATIONS HC NETWORK, LLC	100.00%	4,546	4,546	35
36	V	32	INTEREST		GENERATIONS HC NETWORK, LLC	100.00%	3,789	3,789	36
37	V	33	REAL ESTATE TAXES		GENERATIONS HC NETWORK, LLC	100.00%	5,662	5,662	37
38	V								38
39	Total		\$ 74,699				\$ 181,478	\$ * 106,779	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	06 Maintenance	\$	MAC Rx, LLC	100.00%	\$		15
16	V	10 Nursing and Medical Records	15,158	MAC Rx, LLC	100.00%	13,906	(1,252)	16
17	V	10A Therapy		MAC Rx, LLC	100.00%			17
18	V	19 Professional Services		MAC Rx, LLC	100.00%			18
19	V	21 Clerical & General Office Expenses	366	MAC Rx, LLC	100.00%	336	(30)	19
20	V	22 Employee Benefits	2,027	MAC Rx, LLC	100.00%	1,860	(167)	20
21	V	39 Ancillary	182,391	MAC Rx, LLC	100.00%	167,325	(15,066)	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		\$ 199,942			\$ 183,427	\$ * (16,515)	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	1 Dietary	\$ 26,483	Big Ten Supply, LLC	100.00%	\$ 24,187	\$ (2,296)
16	V	3 Housekeeping	42,437	Big Ten Supply, LLC	100.00%	38,758	(3,679)
17	V	4 Laundry	7,815	Big Ten Supply, LLC	100.00%	7,138	(677)
18	V	6 Repairs & Maintenance	690	Big Ten Supply, LLC	100.00%	630	(60)
19	V	10 Nursing And Medical Records	95,469	Big Ten Supply, LLC	100.00%	87,194	(8,275)
20	V	10A Therapy	54,326	Big Ten Supply, LLC	100.00%	49,617	(4,709)
21	V	21 Clerical & General	324	Big Ten Supply, LLC	100.00%	296	(28)
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 227,543			\$ 207,819	\$ * (19,724)

* 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

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:

01/01/17

Ending:

12/31/17

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1	Bryan Barrish	Relative	Administrative		See Attached	1.75	4.38%	Alloc. Salary	\$ 10,005	17-7	1	
2	Sarah Barrish	Relative	Administrative		See Attached	2.5	5.00%	Alloc. Salary	6,242	17-7	2	
3	Louise Bergthold	Shareholder	Administrative	1.13%	See Attached	3.0	5.00%	Alloc. Salary	10,005	17-7	3	
4	Thomas Bergthold	Relative	Clerical		See Attached	2.0	5.00%	Alloc. Salary	2,086	21-7	4	
5	Andrew Chin	Relative	Clerical		See Attached	2.0	5.00%	Alloc. Salary	4,031	21-7	5	
6	Fay Chin	Shareholder	Nursing	1.13%	See Attached	2.0	5.00%	Alloc. Salary	5,374	10-7	6	
7	Clark Collins	Relative	Administrative		See Attached	3.94	9.85%	Alloc. Salary	4,929	Var.	7	
8	Lynn Ethell	Shareholder	Clerical	1.13%	See Attached	1.5	5.00%	Alloc. Salary	2,475	21-7	8	
9	Mike Giannini	Relative	Administrative		See Attached	1.75	4.38%	Alloc. Salary	8,504	17-7	9	
10	Nenita Guzman	Shareholder	Dietary	1.13%	See Attached	2.5	5.00%	Alloc. Salary	4,981	1-7	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	\$ 58,632		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:

01/01/17

Ending: 12/31/17

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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:

01/01/17

Ending: 12/31/17

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 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	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	REPAIRS AND MAINT.	PATIENT DAYS	693,985	14	\$ 177,702	\$ 95,737	34,716	\$ 8,889	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	693,985	14	16,617		34,716	831	2
3	9	MEDICAL DIRECTOR CONSUM	PATIENT DAYS	693,985	14	82,000		34,716	4,102	3
4	10	NURSING	PATIENT DAYS	693,985	14	589,441	589,441	34,716	29,486	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	693,985	14	73,484		34,716	3,676	5
6	17	ADMINISTRATIVE	PATIENT DAYS	693,985	14	339,126	339,126	34,716	16,964	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	693,985	14	21,409		34,716	1,071	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	693,985	14	3,801		34,716	190	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	693,985	14	1,843,191	1,656,700	34,716	92,204	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	693,985	14	2,295		34,716	115	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	693,985	14	140,164		34,716	7,012	11
12	26	INSURANCE	PATIENT DAYS	693,985	14	23,394		34,716	1,170	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	693,985	14	182,645		34,716	9,137	13
14	32	INTEREST	PATIENT DAYS	693,985	14	(56,845)		34,716	(2,844)	14
15	35	AUTO RENTAL	PATIENT DAYS	693,985	14	51,827		34,716	2,593	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	693,985	14	11,377		34,716	569	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,501,628	\$ 2,681,003		\$ 175,165	25

Facility Name & ID Number Generations at Rock Island

0049866

Report Period Beginning:

01/01/17

Ending: 12/31/17

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 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	693,985	14	\$ 99,579	\$ 34,716	\$ 4,981	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	693,985	14	17,250	34,716	863	2
3	10	NURSING SALARIES	PATIENT DAYS	693,985	14	107,435	34,716	5,374	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	693,985	14	18,544	34,716	928	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	693,985	14	1,421,258	34,716	71,097	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	693,985	14	200,000	34,716	10,005	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	693,985	14	350,079	34,716	17,512	7
8									8
9									9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	329,142	13	179,343	17,412	9,487	10
11	15	EMPLOYEE BENEFITS	SPECIAL REHAB INC.	329,142	13	31,236	17,412	1,652	11
12									12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	366,497	14	376,026	35,627	36,553	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	366,497	14	68,296	35,627	6,639	14
15									15
16	5	UTILITIES	ALLOCATED SQ FT	12,877	14	25,758	644	1,288	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,877	14	16,130	644	807	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,877	14	1,139	644	57	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,877	14	2,063	644	103	19
20	26	INSURANCE	ALLOCATED SQ FT	12,877	14	2,682	644	134	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,877	14	90,892	644	4,546	21
22	32	INTEREST	ALLOCATED SQ FT	12,877	14	75,767	644	3,789	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,877	14	113,223	644	5,662	23
24									24
25	TOTALS					\$ 3,196,700	\$ 2,183,641	\$ 181,478	25

Facility Name & ID Number Generations at Rock Island

0049866

Report Period Beginning:

01/01/17

Ending: 12/31/17

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 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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	06	Maintenance	Direct Allocation		\$	\$		\$	1
2	10	Nursing And Medical Records	Direct Allocation					13,906	2
3	10A	Therapy	Direct Allocation						3
4	19	Professional Services	Direct Allocation						4
5	21	Clerical & General Office Expense	Direct Allocation					336	5
6	22	Employee Benefits	Direct Allocation					1,860	6
7	39	Ancillary	Direct Allocation					167,325	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				\$	\$		\$ 183,427	25

Facility Name & ID Number Generations at Rock Island

0049866

Report Period Beginning:

01/01/17

Ending: 12/31/17

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 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation		\$	\$		24,187	1
2	3	Housekeeping	Direct Allocation					38,758	2
3	4	Laundry	Direct Allocation					7,138	3
4	6	Repairs & Maintenance	Direct Allocation					630	4
5	10	Nursing And Medical Records	Direct Allocation					87,194	5
6	10A	Therapy	Direct Allocation					49,617	6
7	21	Clerical & General	Direct Allocation					296	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				\$	\$		207,819	25

Facility Name & ID Number Generations at Rock Island

0049866

Report Period Beginning:

01/01/17

Ending: 12/31/17

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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:

01/01/17

Ending: 12/31/17

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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:

01/01/17

Ending: 12/31/17

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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: 01/01/17 Ending: 12/31/17

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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:

01/01/17

Ending: 12/31/17

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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:

01/01/17

Ending:

12/31/17

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			\$	4,502,979		\$	163,582	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	Lake Forest Bank & Trust		X	Shareholder Loan				1,540,000			48,881	6								
7	Lake Forest Bank & Trust		X	Line of Credit				860,000				7								
8												8								
9	TOTAL Facility Related						\$	6,902,979		\$	212,463	9								
B. Non-Facility Related*																				
10	Interest Income		X								(1,794)	10								
11	Interest Income-Bldg Co		X								(654)	11								
12	Allocated from Generations He	X									3,789	12								
13	See Supplemental Schedule										(2,844)	13								
14	TOTAL Non-Facility Related						\$			\$	(1,503)	14								
15	TOTALS (line 9+line14)						\$	6,902,979		\$	210,960	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 22,783 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.)

2016 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 Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>10-341-78-00</u>	<u>Long Term Care Property</u>	\$ <u>107,230.76</u>	\$ <u>107,230.76</u>
2.	<u>10-341-79-00</u>	<u>Long Term Care Property</u>	\$ <u>1,527.20</u>	\$ <u>1,527.20</u>
3.	<u>10-31-401-046-0000</u>	<u>Allocated from Regency</u>	\$ <u>848,962.66</u>	\$ <u>257.93</u>
4.	<u>See Attached</u>	<u>Allocated from S.I.R. Properties</u>	\$ <u>131,016.59</u>	\$ <u>5,131.52</u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS			\$ <u><u>1,088,737.21</u></u>	\$ <u><u>114,147.41</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

Facility Name & ID Number Generations at Rock Island

0049866 Report Period Beginning:

01/01/17 Ending:

12/31/17

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 (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? (a) Own the Equipment (b) Rent equipment from a Related Organization. (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 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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Facility, 224,770, 1997, \$ 420,000, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 224,770, (blank), \$ 420,000, 3.

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	177		1975	\$ 3,579,244	\$ 201,946	39	\$ 91,775	\$ (110,171)	\$ 1,870,665	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Various		2002	10,887		20	396	396	5,967	9
10	Various		2003	5,954		20	216	216	3,045	10
11	Various		2004	9,240		20	336	336	4,550	11
12	Various		2005	48,760		20	2,139	2,139	26,650	12
13	Various		2006	39,068		20	1,421	1,421	16,727	13
14	Various		2008	539,334		20	48,755	48,755	503,379	14
15	Various		2009	265,059		20	15,135	15,135	129,731	15
16	Various		2010	21,670		20	674	674	13,449	16
17	Various		2011	22,411		20	1,277	1,277	8,226	17
18	Various		2012	2,524		20	126	126	684	18
19	Various		2013	51,415		20	2,571	2,571	12,096	19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

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	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12F & 12G)	519,133			27,072	27,072	195,048	67
68	Related Party Allocations (Pages 12H & 12I)	89,377	2,722		3,180	458	53,310	68
69	Financial Statement Depreciation		114,560			(114,560)		69
70	TOTAL (lines 4 thru 69)	\$ 5,204,075	\$ 319,228		\$ 195,073	\$ (124,155)	\$ 2,843,526	70

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

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		\$ 5,204,075	\$ 319,228		\$ 195,073	\$ (124,155)	\$ 2,843,526	1
2	Elevator Door Operator Board	2014	4,538		20	227	227	889	2
3	Flooring Adm And Front Office	2014	6,766		20	338	338	1,099	3
4	Flooring Adm And Front Office	2014	3,369		20	168	168	547	4
5	Crashrails- 1St Floor Dining Room	2014	2,762		20	138	138	460	5
6	Crashrails- 1St Floor Dining Room	2014	2,577		20	129	129	430	6
7	Crashrails- 1St Floor Dining Room	2014	2,616		20	131	131	436	7
8	Crashrails- 1St Floor Dining Room	2014	4,934		20	247	247	822	8
9	Custom Built In - Front Reception	2014	9,000		20	450	450	1,538	9
10	Handrail Repairs At Nurses Station	2016	3,344		20	167	167	334	10
11	Chiller Repairs	2016	2,595		20	130	130	205	11
12	Flooring & Wall Base 2Nd Floor Corridors	2017	4,929		20	41	41	41	12
13	Repaired A/C	2017	2,996		20	150	150	150	13
14	Colid Cleaner Hvac	2017	2,619		20	131	131	131	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,257,120	\$ 319,228		\$ 197,520	\$ (121,708)	\$ 2,850,609	34

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

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		\$ 5,257,120	\$ 319,228		\$ 197,520	\$ (121,708)	\$ 2,850,609	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 5,257,120	\$ 319,228		\$ 197,520	\$ (121,708)	\$ 2,850,609	34

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

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		\$ 5,257,120	\$ 319,228		\$ 197,520	\$ (121,708)	\$ 2,850,609	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 5,257,120	\$ 319,228		\$ 197,520	\$ (121,708)	\$ 2,850,609	34

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

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		\$ 5,257,120	\$ 319,228		\$ 197,520	\$ (121,708)	\$ 2,850,609	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 5,257,120	\$ 319,228		\$ 197,520	\$ (121,708)	\$ 2,850,609	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:

01/01/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	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	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	3,310	3,310	49,467	9
10	Windows	1998	2,278		20	114	114	1,633	10
11	Walk in Freezer Compressor	2000	2,097		20			2,097	11
12	Electrical Work	2001	1,854		20	93	93	1,313	12
13	Water Heater	2008	6,570		20	329	329	4,606	13
14	Handrails	2008	100,904		20	5,045	5,045	70,630	14
15	Electrical Work-Resident Rooms	2010	7,985		20	399	399	2,793	15
16	Wall Removal - 4th Floor Dining	2010	7,000		20	405	405	2,835	16
17	Outdoor Fence	2010	6,570		20	329	329	2,303	17
18	Kitchen Lighting	2010	8,026		20	803	803	5,621	18
19	Flooring- Carpet and Tile	2011	7,869		20	393	393	2,358	19
20	Fire-Sprinkler Heads	2011	2,790		20	140	140	840	20
21	Outdoor Facility Light sign	2012	10,113		20	506	506	2,530	21
22	Compressor for Walk in Freezer	2012	5,820		20	291	291	1,455	22
23	Dialysis Room- New: Construction, plumbing, HVAC & Electrical	2012	42,518		20	2,126	2,126	10,630	23
24	Nurse Call System	2012	7,800		20	390	390	1,950	24
25	Installed Amtico Flooring on 1st Floor Therapy Room	2013	9,999		20	500	500	2,000	25
26	Installed Cabinetry, Countertop Finish & Molding in Physical	2013	12,400		20	620	620	2,480	26
27	Installed Nurse Station	2013	25,000		20	1,250	1,250	5,000	27
28	Installed Elevator Panel	2013	8,000		20	400	400	1,600	28
29	Installed Cabinetry	2013	5,000		20	250	250	1,000	29
30	Replacment Windows	2013	9,133		20	457	457	1,827	30
31	Install Flooring & Walls in Break Room & Adjoining Bathroom	2014	4,330		20	216	216	648	31
32	Kitchen Floor Tile	2015	17,653		20	883	883	2,649	32
33	Asphalt & Concrete Work	2015	69,600		20	3,480	3,480	10,440	33
34	TOTAL (lines 1 thru 33)		\$ 432,273	\$		\$ 22,729	\$ 22,729	\$ 190,705	34

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

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	\$		\$ 22,729	\$	\$ 190,705	1
2	Wall-guards in Hallways	2017	7,541		20	377	377	377	2
3	Installed New Hydrant	2017	5,845		20	292	292	292	3
4	Install new car Sills-Elevator	2017	6,214		20	311	311	311	4
5	Landscaping work, new plants	2017	5,551		20	278	278	278	5
6	Concrete removal & repaving	2017	56,086		20	2,804	2,804	2,804	6
7	Wall A/C 3 & scale	2017	2,975		20	149	149	149	7
8	Replace Handrails/Corner Guards Throughout Facility, As Needed	2017	2,648		20	132	132	132	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 519,133	\$		\$ 27,072	\$ 4,343	\$ 195,048	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:

01/01/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	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	2009	12,503	332	39	321	(11)	2,578	3
4	Allocated from S.I.R. Properties - GHN	1993	22,638	719	35	647	(72)	15,847	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Generations Healthcare Network	1993	5,740	160	20		(160)	5,740	9
10	Allocated from Generations Healthcare Network	1994	18		20			18	10
11	Allocated from Generations Healthcare Network	1995	131		20			131	11
12	Allocated from Generations Healthcare Network	1997	8,819	395	20	148	(247)	8,819	12
13	Allocated from Generations Healthcare Network	1999	693		20	35	35	632	13
14	Allocated from Generations Healthcare Network	2000	819		20	41	41	718	14
15	Allocated from Generations Healthcare Network	2007	2,631		20	132	132	1,341	15
16	Allocated from Generations Healthcare Network	2008	7,250	725	20	457	(268)	4,498	16
17	Allocated from Generations Healthcare Network	2009	18,015	165	20	901	736	7,426	17
18	Allocated from Generations Healthcare Network	2011	446	45	20	45		286	18
19	Allocated from Generations Healthcare Network	2012	1,426	71	20	71		396	19
20	Allocated from Generations Healthcare Network	2014	200	20	20	10	(10)	36	20
21	Allocated from Generations Healthcare Network	2016	260	13		13		18	21
22									22
23	Allocated from S.I.R. Properties - GHN	2012	1,387	61	20	69	8	347	23
24	Allocated from S.I.R. Properties - GHN	2010	1,366		20	68	68	501	24
25	Allocated from S.I.R. Properties - GHN	2009	1,359		20	68	68	598	25
26	Allocated from S.I.R. Properties - GHN	2007	134	8	20	7	(1)	74	26
27	Allocated from S.I.R. Properties - GHN	2002	90		20	4	4	70	27
28	Allocated from S.I.R. Properties - GHN	1999	2,869		20	143	143	2,653	28
29	Allocated from S.I.R. Properties - GHN	1994	216	6	20		(6)	216	29
30	Allocated from S.I.R. Properties - GHN	1993	367	2	20		(2)	367	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 89,377	\$ 2,722		\$ 3,180	\$ 458	\$ 53,310	34

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

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		\$ 89,377	\$ 2,722		\$ 3,180	\$ 458	\$ 53,310	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 89,377	\$ 2,722		\$ 3,180	\$ 458	\$ 53,310	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:

01/01/17

Ending:

12/31/17

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	\$ 910,316	\$ 1,672	\$ 90,898	\$ 89,226	10	\$ 625,731	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	516,694		784	784	10	516,514	73
74								74
75	TOTALS	\$ 1,427,010	\$ 1,672	\$ 91,682	\$ 90,010		\$ 1,142,245	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		Allocated from Generations Heal	1900	\$ 1,758	\$ 154	\$ 116	\$ (38)	5	\$ 1,468	76
77										77
78										78
79										79
80	TOTALS			\$ 1,758	\$ 154	\$ 116	\$ (38)		\$ 1,468	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)	\$ 7,105,888	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 321,054	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 289,318	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (31,736)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,994,322	85

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

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

G. Construction-in-Progress

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

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

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

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending	Annual Rent
--------------------	-------------

12.	/2018	\$	_____
13.	/2019	\$	_____
14.	/2020	\$	_____

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: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 3,304

Description: See Attached Schedule

(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	<u>Allocated from Generations Healthcare Network</u>		\$	<u>2,593</u>	17
18					18
19					19
20					20
21	TOTAL		\$	2,593	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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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		3		4		5	6	7	8		
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)					Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	197,580	\$			\$	197,580	1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				35,365					35,365	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	39 - 03	hrs				231,224					231,224	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						182,836			182,836	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Other (specify): _____												12	
13	Other (specify): <u>See Supplemental</u>				258,958		93,993		156,900			509,851	13	
14	TOTAL			\$	258,958		\$	558,162	\$	339,736		\$	1,156,856	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.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 28,710	\$ 70,813	1
2	Cash-Patient Deposits	42,382	42,382	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,583,909	1,583,909	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	54,038	54,529	6
7	Other Prepaid Expenses	65,322	65,322	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	17,390	335,542	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,791,751	\$ 2,152,497	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		5,434,607	14
15	Leasehold Improvements, at Historical Cost	794,924	1,392,453	15
16	Equipment, at Historical Cost	607,952	852,950	16
17	Accumulated Depreciation (book methods)	(985,854)	(2,315,749)	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): <u>See Attached Schedule</u>		61,766	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 417,022	\$ 5,426,027	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,208,773	\$ 7,578,524	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 670,443	\$ 670,443	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	42,382	42,382	28
29	Short-Term Notes Payable	2,400,000	2,400,000	29
30	Accrued Salaries Payable	134,845	134,845	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,906	7,906	31
32	Accrued Real Estate Taxes(Sch.IX-B)		114,200	32
33	Accrued Interest Payable		13,471	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	41,473	41,473	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,297,049	\$ 3,424,720	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,502,979	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 4,502,979	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,297,049	\$ 7,927,699	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,088,276)	\$ (349,175)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,208,773	\$ 7,578,524	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 362,241	1
2	Restatements (describe):		2
3	<u>Rounding</u>	(2)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 362,239	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,450,515)	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)	\$ (1,450,515)	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)	\$ (1,088,276)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Generations at Rock Island

0049866

Report Period Beginning: 01/01/17

Ending:

12/31/17

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		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,968,439	1
2	Discounts and Allowances for all Levels	(1,569,843)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,398,596	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,541,337	6
7	Oxygen	51,866	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,593,203	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	664	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	165,531	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,527	19
20	Radiology and X-Ray	1,917	20
21	Other Medical Services	33,332	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 209,971	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,794	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,794	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	15	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 15	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,203,579	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,391,820	31
32	Health Care	3,550,758	32
33	General Administration	1,575,923	33
B. Capital Expense			
34	Ownership	688,426	34
C. Ancillary Expense			
35	Special Cost Centers	1,156,856	35
36	Provider Participation Fee	290,311	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,654,094	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,450,515)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,450,515)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,048,330	44
45	Private Pay - Net Inpatient Revenue	162,797	45
46	Medicare - Net Inpatient Revenue	587,567	46
47	Other-(specify) <u>Managed Care/Insurance</u>	398,620	47
48	Other-(specify) <u>Hospice</u>	201,282	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,398,596	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:

01/01/17

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12/31/17

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,674	1,818	\$ 68,793	\$ 37.84	1
2	Assistant Director of Nursing	462	462	15,245	33.00	2
3	Registered Nurses	7,334	7,587	223,445	29.45	3
4	Licensed Practical Nurses	27,001	29,118	642,991	22.08	4
5	CNAs & Orderlies	65,270	68,740	879,942	12.80	5
6	CNA Trainees					6
7	Licensed Therapist	9,195	9,826	258,958	26.35	7
8	Rehab/Therapy Aides	7,589	8,343	128,750	15.43	8
9	Activity Director					9
10	Activity Assistants	7,877	8,612	108,102	12.55	10
11	Social Service Workers	13,540	14,720	223,678	15.20	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,982	20,875	203,837	9.76	15
16	Dishwashers					16
17	Maintenance Workers	3,753	4,043	59,168	14.63	17
18	Housekeepers	16,598	17,557	168,183	9.58	18
19	Laundry	8,269	8,675	86,747	10.00	19
20	Administrator	1,953	2,086	96,518	46.27	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,212	8,561	154,513	18.05	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	4,008	4,370	75,533	17.28	31
32	Other Health Care(specify)					32
33	Other(specify)	231	231	952	4.12	33
34	TOTAL (lines 1 - 33)	202,948	215,624	\$ 3,395,355 *	\$ 15.75	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 44,400	01-03	35
36	Medical Director	Monthly	66,000	09-03	36
37	Medical Records Consultant	Monthly	2,815	10-03	37
38	Nurse Consultant	Monthly	56,292	10-03	38
39	Pharmacist Consultant	Monthly	8,315	10-03	39
40	Physical Therapy Consultant	Monthly	2,242	10a-03	40
41	Occupational Therapy Consultant	Monthly	2,154	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	859	10a-03	43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	1,955	12-03	45
46	Other(specify)				46
47	Specialized Rehab	Monthly	17,412	10a-03	47
48					48
49	TOTAL (lines 35 - 48)	2	\$ 202,444		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	5,500	\$ 275,023	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	22,172	554,290	10-03	52
53	TOTAL (lines 50 - 52)	27,672	\$ 829,313		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount			
Elizabeth Webster	Administrator	0	\$ 96,518	Workers' Compensation Insurance	\$ 72,488	IDPH License Fee	\$ 1,992			
				Unemployment Compensation Insurance	41,451	Advertising: Employee Recruitment	11,392			
				FICA Taxes	254,674	Health Care Worker Background Check				
				Employee Health Insurance	109,348	(Indicate # of checks performed 149)	1,485			
				Employee Meals	23,199	Patient Background Checks	116			
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	20,999			
				401K	1,200	Licenses & Permits	7,270			
				Other Employee Benefits	11,207	Allocated from Generations Healthcare Network	190			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 96,518	TOTAL (agree to Schedule V, line 22, col.8)			\$ 513,568	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 44,488
(List each licensed administrator separately.)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
B. Administrative - Other				Description	Line #	Amount	Description	Amount		
Description										
Director of Administrative Services- Generation HN						\$ 52,044	Out-of-State Travel	\$		
Ancillary Administrative Charges- Generations HN						43,548	In-State Travel			
TOTAL (agree to Schedule V, line 17, col. 3)						\$ 95,592	Seminar Expense	6,194		
(Attach a copy of any management service agreement)							Allocated from Generations Healthcare Network	115		
C. Professional Services				TOTAL			Entertainment Expense			
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)			
SIR/Generations HN	Dir. Of Financial Svc		\$ 42,900				TOTAL		\$ 6,309	
SIR/Generations HN	Dir. Of Marketing & Admissions		36,852							
SIR/Generations HN	Dir. Of Regulatory Svc		26,016							
Marcum LLP	Accounting		16,110							
SIR/Generations HN	Bookkeeping		92,712							
SIR/Generations HN	Computer Support		23,892							
Legal Fees	See Attached		44,811							
Personnel Planners	Unemployment Tax Consult		1,380							
Achieve Accreditation	Accreditation		10,997							
HK Payroll	Payroll		7,970							
Pinnacle	Customer Satisfaction		2,897							
See Supplemental Schedule			29,250							
TOTAL (agree to Schedule V, line 19, column 3)			\$ 335,788							
(For legal fee disclosure, see page 39 of instructions)										

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Generations at Rock Island

0049866

Report Period Beginning:

01/01/17

Ending:

12/31/17

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. ILCLTC-\$21507.28
- (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. \$ 19,767 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 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. \$ 290,311
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. \$ 23,199 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 664
- (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? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? N/A
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees