

Facility Name & ID Number Generations At Applewood Llc

0051359 Report Period Beginning: 01/01/18 Ending: 12/31/18

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 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	115	Skilled (SNF)	115	41,975	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	115	TOTALS	115	41,975	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	7,739	2,677	21,604	32,020	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,739	2,677	21,604	32,020	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.28%

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 3/1/11

J. Was the facility purchased or leased after January 1, 1978?
YES Date 3/1/11 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 115 and days of care provided 3,584

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

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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	253,402	26,262	17,946	297,610		297,610	(5,815)	291,795		1
2	Food Purchase		193,663		193,663		193,663	(162)	193,501		2
3	Housekeeping	200,391	32,010		232,401		232,401	(2,801)	229,600		3
4	Laundry	20,048	4,237	114,883	139,168		139,168	(108)	139,060		4
5	Heat and Other Utilities			208,694	208,694		208,694	(27,205)	181,489		5
6	Maintenance	60,822	38,851	171,913	271,586		271,586	(1,989)	269,597		6
7	Other (specify):*							9,450	9,450		7
8	TOTAL General Services	534,663	295,023	513,436	1,343,122		1,343,122	(28,630)	1,314,492		8
	B. Health Care and Programs										
9	Medical Director			47,500	47,500		47,500		47,500		9
10	Nursing and Medical Records	2,094,528	222,236	45,230	2,361,994		2,361,994	(25,734)	2,336,260		10
10a	Therapy	128,990		30,036	159,026		159,026	(1,826)	157,200		10a
11	Activities	116,726	6,456	629	123,811		123,811		123,811		11
12	Social Services	93,387			93,387		93,387		93,387		12
13	CNA Training										13
14	Program Transportation			1,468	1,468		1,468		1,468		14
15	Other (specify):*							4,643	4,643		15
16	TOTAL Health Care and Programs	2,433,631	228,692	124,863	2,787,186		2,787,186	(22,917)	2,764,269		16
	C. General Administration										
17	Administrative	121,878		73,140	195,018		195,018	9,829	204,847		17
18	Directors Fees										18
19	Professional Services			327,700	327,700	(14,561)	313,139	(208,710)	104,429		19
20	Dues, Fees, Subscriptions & Promotions			62,568	62,568		62,568	(31,928)	30,640		20
21	Clerical & General Office Expenses	131,310	25,802	111,199	268,311		268,311	13,438	281,749		21
22	Employee Benefits & Payroll Taxes			469,044	469,044		469,044	(145)	468,899		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,550	1,550		1,550	156	1,706		24
25	Other Admin. Staff Transportation			25,097	25,097		25,097	9,920	35,017		25
26	Insurance-Prop.Liab.Malpractice			156,243	156,243		156,243	1,010	157,253		26
27	Other (specify):*							21,282	21,282		27
28	TOTAL General Administration	253,188	25,802	1,226,541	1,505,531	(14,561)	1,490,970	(185,148)	1,305,822		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,221,482	549,517	1,864,840	5,635,839	(14,561)	5,621,278	(236,695)	5,384,583		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 Applewood Llc

#0051359

Report Period Beginning:

01/01/18

Ending:

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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			82,425	82,425		82,425	30,949	113,374			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			69,533	69,533		69,533	(46,554)	22,979			32
33	Real Estate Taxes			528,000	528,000	14,561	542,561	9,368	551,929			33
34	Rent-Facility & Grounds			781,829	781,829		781,829	(781,829)				34
35	Rent-Equipment & Vehicles			2,468	2,468		2,468	2,342	4,810			35
36	Other (specify):*											36
37	TOTAL Ownership			1,464,255	1,464,255	14,561	1,478,816	(785,724)	693,092			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		137,976	639,488	777,464		777,464	(10,839)	766,625			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			224,653	224,653		224,653		224,653			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		137,976	864,141	1,002,117		1,002,117	(10,839)	991,278			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,221,482	687,493	4,193,236	8,102,211		8,102,211	(1,033,258)	7,068,953			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 Applewood Llc

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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				4
5	Telephone, TV & Radio in Resident Rooms	(28,367)	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	(54,467)	30		9
10	Interest and Other Investment Income	(8,420)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(162)	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	(1,967)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(40,306)	21		24
25	Fund Raising, Advertising and Promotional	(25,115)	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	(57,775)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (216,579)		\$	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	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)	(816,679)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (816,679)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,033,258)		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

Generations At Applewood Llc

ID# 0051359

Report Period Beginning: 01/01/18

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Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Bank Fees	\$ (6,508)	21	1
2	Credit Card Fees	(482)	21	2
3	Theft & Damages Loss	(831)	21	3
4	Non-Allowable Interest	(24,760)	32	4
5	Additional R & M	5,629	06	5
6	Capitalized R & M	(11,573)	06	6
7	PAC Dues	(4,909)	20	7
8	Building Co - Management Fee	(8,625)	21	8
9	Building Co - Accounting	(2,450)	19	9
10	Building Co. - Admin Fee	(54)	21	10
11	Building Co. - Filing Fee	(75)	21	11
12	Building Co. - Bank Charges	(4)	21	12
13	Non-Allowable Legal	(3,133)	19	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	(57,775)		49

Generations At Applewood Llc

ID# 0051359
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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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Generations At Applewood Llc# 0051359

Report Period Beginning:

01/01/18

Ending:

12/31/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(5,815)								(5,815)	1
2	Food Purchase	(162)											(162)	2
3	Housekeeping						(2,801)						(2,801)	3
4	Laundry						(108)						(108)	4
5	Heat and Other Utilities	(28,367)			1,162								(27,205)	5
6	Maintenance	(5,944)		(2,033)	9,350		(3,362)						(1,989)	6
7	Other (specify):*			679	8,771								9,450	7
8	TOTAL General Services	(34,473)		(1,354)	13,468		(6,271)						(28,630)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(16,158)	4,366	(1,194)	(12,749)						(25,734)	10
10a	Therapy				(1,826)								(1,826)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			3,298	1,345								4,643	15
16	TOTAL Health Care and Programs			(12,860)	3,886	(1,194)	(12,749)						(22,917)	16
	C. General Administration													
17	Administrative			(57,774)	67,603								9,829	17
18	Directors Fees													18
19	Professional Services	(5,583)	2,450	(213,773)	8,196								(208,710)	19
20	Fees, Subscriptions & Promotions	(31,991)		63									(31,928)	20
21	Clerical & General Office Expenses	(56,885)	8,758	61,574	62	(71)							13,438	21
22	Employee Benefits & Payroll Taxes					(145)							(145)	22
23	Inservice Training & Education													23
24	Travel and Seminar			156									156	24
25	Other Admin. Staff Transportation			9,920									9,920	25
26	Insurance-Prop.Liab.Malpractice			866	144								1,010	26
27	Other (specify):*			5,459	15,823								21,282	27
28	TOTAL General Administration	(94,459)	11,208	(193,509)	91,828	(216)							(185,148)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(128,932)	11,208	(207,723)	109,182	(1,410)	(19,019)						(236,695)	29

STATE OF ILLINOIS

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Report Period Beginning:

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Ending:

Summary B

12/31/18

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(54,467)	82,292		3,124								30,949	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(33,180)		(16,205)	2,831								(46,554)	32
33	Real Estate Taxes		4,868		4,500								9,368	33
34	Rent-Facility & Grounds		(781,829)										(781,829)	34
35	Rent-Equipment & Vehicles			2,342									2,342	35
36	Other (specify):*													36
37	TOTAL Ownership	(87,647)	(694,669)	(13,863)	10,455								(785,724)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(10,839)							(10,839)	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					(10,839)							(10,839)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(216,579)	(683,461)	(221,586)	119,637	(12,249)	(19,019)						(1,033,258)	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 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. 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		
1	V	34 Rent	\$ 781,829	Applewood Property, LLC		\$	\$ (781,829)	1
2	V	33 Real Estate Taxes	528,000	Applewood Property, LLC		532,868	4,868	2
3	V	21 Management Fee		Applewood Property, LLC		8,625	8,625	3
4	V	19 Accounting Fee		Applewood Property, LLC		2,450	2,450	4
5	V	21 Bank Service Charge		Applewood Property, LLC		4	4	5
6	V	21 Filing Fee		Applewood Property, LLC		75	75	6
7	V	30 Depreciation		Applewood Property, LLC		82,292	82,292	7
8	V	21 Other Admin Expenses		Applewood Property, LLC		54	54	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,309,829			\$ 626,368	\$ * (683,461)	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.	\$ 9,660	GENERATIONS HC NETWORK, LLC		\$ 7,627	\$ (2,033)
16	V	7 EMP. BEN.-GEN. SERV.		GENERATIONS HC NETWORK, LLC		679	679
17	V	9 MEDICAL DIRECTOR CONSULTS		GENERATIONS HC NETWORK, LLC			
18	V	10 NURSING	35,880	GENERATIONS HC NETWORK, LLC		19,722	(16,158)
19	V	15 EMP. BEN.-H.C.		GENERATIONS HC NETWORK, LLC		3,298	3,298
20	V	17 ADMINISTRATIVE	73,140	GENERATIONS HC NETWORK, LLC		15,366	(57,774)
21	V	19 PROFESSIONAL FEES	219,900	GENERATIONS HC NETWORK, LLC		6,127	(213,773)
22	V	20 FEES,SUBSCRIPTIONS		GENERATIONS HC NETWORK, LLC		63	63
23	V	21 CLERICAL & GENERAL	24,840	GENERATIONS HC NETWORK, LLC		86,414	61,574
24	V	24 EDUCATION & SEMINAR		GENERATIONS HC NETWORK, LLC		156	156
25	V	25 OTHER ADMIN. STAFF TRANS.		GENERATIONS HC NETWORK, LLC		9,920	9,920
26	V	26 INSURANCE		GENERATIONS HC NETWORK, LLC		866	866
27	V	27 EMP. BEN.-GEN. ADMIN.		GENERATIONS HC NETWORK, LLC		5,459	5,459
28	V	32 INTEREST		GENERATIONS HC NETWORK, LLC		(16,205)	(16,205)
29	V	35 AUTO RENTAL		GENERATIONS HC NETWORK, LLC		1,889	1,889
30	V	35 EQUIPMENT RENTAL		GENERATIONS HC NETWORK, LLC		453	453
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 363,420			\$ 141,834	\$ * (221,586)

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

Facility Name & ID Number

Generations At Applewood Llc

0051359

Report Period Beginning:

01/01/18

Ending:

12/31/18

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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	\$ 9,660	GENERATIONS HC NETWORK, LLC	\$ 3,845	\$(5,815)
16	V	7	EMP. BEN.-DIETARY		GENERATIONS HC NETWORK, LLC	644	644
17	V	10	NURSING SALARIES		GENERATIONS HC NETWORK, LLC	4,366	4,366
18	V	15	EMP. BEN.-NURSING		GENERATIONS HC NETWORK, LLC	726	726
19	V	17	ADMIN./LEGAL SALARIES		GENERATIONS HC NETWORK, LLC	67,603	67,603
20	V	19	FIN. CONSULT./REGL. DIR.		GENERATIONS HC NETWORK, LLC	8,023	8,023
21	V	27	EMP. BEN.-ADMINISTRATIVE		GENERATIONS HC NETWORK, LLC	15,823	15,823
22	V						
23	V						
24	V	10A	DIRECTOR OF SPECIAL REHAB	5,520	GENERATIONS HC NETWORK, LLC	3,694	\$(1,826)
25	V	15	EMPLOYEE BENEFITS		GENERATIONS HC NETWORK, LLC	619	619
26	V						
27	V	6	MAINTENANCE SALARIES	37,352	GENERATIONS HC NETWORK, LLC	46,030	8,678
28	V	7	EMPLOYEE BENEFITS		GENERATIONS HC NETWORK, LLC	8,127	8,127
29	V						
30	V	5	UTILITIES		GENERATIONS HC NETWORK, LLC	1,162	1,162
31	V	6	REPAIRS AND MAINT.		GENERATIONS HC NETWORK, LLC	672	672
32	V	19	PROFESSIONAL FEES		GENERATIONS HC NETWORK, LLC	173	173
33	V	21	CLERICAL & GENERAL		GENERATIONS HC NETWORK, LLC	62	62
34	V	26	INSURANCE		GENERATIONS HC NETWORK, LLC	144	144
35	V	30	DEPRECIATION		GENERATIONS HC NETWORK, LLC	3,124	3,124
36	V	32	INTEREST		GENERATIONS HC NETWORK, LLC	2,831	2,831
37	V	33	REAL ESTATE TAXES		GENERATIONS HC NETWORK, LLC	4,500	4,500
38	V						
39	Total		\$ 52,532			\$ 172,169	\$ * 119,637

* 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		\$	\$	15
16	V	10 Nursing and Medical Records	13,852	MAC Rx, LLC		12,658	(1,194)	16
17	V	10A Therapy		MAC Rx, LLC				17
18	V	19 Professional Services		MAC Rx, LLC				18
19	V	21 Clerical & General Office Expenses	827	MAC Rx, LLC		756	(71)	19
20	V	22 Employee Benefits	1,681	MAC Rx, LLC		1,536	(145)	20
21	V	39 Ancillary	125,768	MAC Rx, LLC		114,929	(10,839)	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		\$ 142,128			\$ 129,879	\$ * (12,249)	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	\$	Big Ten Supply, LLC	100.00%	\$	\$
16	V	3 Housekeeping	29,250	Big Ten Supply, LLC	100.00%	26,449	(2,801)
17	V	4 Laundry	1,128	Big Ten Supply, LLC	100.00%	1,020	(108)
18	V	6 Repairs & Maintenance	35,106	Big Ten Supply, LLC	100.00%	31,744	(3,362)
19	V	10 Nursing And Medical Records	133,131	Big Ten Supply, LLC	100.00%	120,382	(12,749)
20	V	10A Therapy		Big Ten Supply, LLC	100.00%		
21	V	21 Clerical & General		Big Ten Supply, LLC	100.00%		
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		\$ 198,614			\$ 179,595	\$ * (19,019)

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

Facility Name & ID Number

Generations At Applewood Llc

0051359

Report Period Beginning:

01/01/18

Ending:

12/31/18

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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 Applewood Llc

0051359

Report Period Beginning:

01/01/18

Ending:

12/31/18

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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 Applewood Llc

0051359

Report Period Beginning:

01/01/18

Ending:

12/31/18

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		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 Applewood Llc

0051359

Report Period Beginning:

01/01/18

Ending:

12/31/18

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

1	2	3	4	5	6		7		8	9	
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**				
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference		
1	Elka Abramchick	Relative		Clerical	See Attached	1.26	3.94%	Alloc. Salary	\$ 1,841	21-7	1
2	Joey Abramchik	Relative		Administrative	See Attached	1.57	3.94%	Alloc. Salary	8,023	17-7	2
3	Bryan Barrish	Relative		Administrative	See Attached	1.38	3.44%	Alloc. Salary	9,841	17-7	3
4	Kirsten Schloss	Relative		Maintenance	See Attached	1.57	3.94%	Alloc. Salary	4,060	6-7	4
5	Sarah Barrish	Owner	1.60%	Administrative	See Attached	1.97	3.94%	Alloc. Salary	4,950	17-7	5
6	Louise Bergthold	Owner	1.60%	Administrative	See Attached	2.36	3.94%	Alloc. Salary	9,841	17-7	6
7	Michael Giannini	Relative		Administrative	See Attached	1.38	3.44%	Alloc. Salary	7,117	17-7	7
8	Nenita Guzman	Relative		Dietary	See Attached	1.97	3.94%	Alloc. Salary	3,845	1-7	8
9	Clark Collins	Relative		Administrative	See Attached	2.81	7.03%	Alloc. Salary	3,513	Various	9
10	See Supplemental Schedule								11,788		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	\$ 64,819		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 Applewood Llc

0051359 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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 Applewood Llc

0051359

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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	813,429	20	\$ 193,743	\$ 103,385	\$ 7,627	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	813,429	20	17,260	32,020	679	2
3	9	MEDICAL DIRECTOR CONSUL	PATIENT DAYS	813,429	20		32,020		3
4	10	NURSING	PATIENT DAYS	813,429	20	501,001	501,001	19,722	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	813,429	20	83,773	32,020	3,298	5
6	17	ADMINISTRATIVE	PATIENT DAYS	813,429	20	390,351	390,351	15,366	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	813,429	20	155,641	32,020	6,127	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	813,429	20	1,590	32,020	63	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	813,429	20	2,195,251	1,959,905	86,414	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	813,429	20	3,956	32,020	156	10
11	25	OTHER ADMIN. STAFF TRANS.	PATIENT DAYS	813,429	20	252,011	32,020	9,920	11
12	26	INSURANCE	PATIENT DAYS	813,429	20	21,989	32,020	866	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	813,429	20	138,692	32,020	5,459	13
14	32	INTEREST	PATIENT DAYS	813,429	20	(411,674)	32,020	(16,205)	14
15	35	AUTO RENTAL	PATIENT DAYS	813,429	20	47,983	32,020	1,889	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	813,429	20	11,512	32,020	453	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,603,079	\$ 2,954,641	\$ 141,834	25

Facility Name & ID Number Generations At Applewood Llc

0051359

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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	813,429	20	\$ 97,690	\$ 32,020	\$ 3,845	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	813,429	20	16,359	32,020	644	2
3	10	NURSING SALARIES	PATIENT DAYS	813,429	20	110,913	110,913	4,366	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	813,429	20	18,452	32,020	726	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	813,429	20	1,717,366	1,717,366	67,603	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	813,429	20	203,820	32,020	8,023	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	813,429	20	401,962	32,020	15,823	7
8									8
9									9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	284,688	14	190,531	190,531	3,694	10
11	15	EMPLOYEE BENEFITS	SPECIAL REHAB INC.	284,688	14	31,950	5,520	619	11
12									12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	368,277	19	453,836	453,836	46,030	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	368,277	19	80,131	37,352	8,127	14
15									15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	20	29,526	507	1,162	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	20	17,073	507	672	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	20	4,403	507	173	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	20	1,572	507	62	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	20	3,650	507	144	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	20	79,352	507	3,124	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	20	71,924	507	2,831	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	20	114,307	507	4,500	23
24									24
25	TOTALS					\$ 3,644,817	\$ 2,570,336	\$ 172,169	25

Facility Name & ID Number Generations At Applewood Llc

0051359

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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					12,658	2
3	10A	Therapy	Direct Allocation						3
4	19	Professional Services	Direct Allocation						4
5	21	Clerical & General Office Expense	Direct Allocation					756	5
6	22	Employee Benefits	Direct Allocation					1,536	6
7	39	Ancillary	Direct Allocation					114,929	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				\$	\$		\$	129,879

Facility Name & ID Number Generations At Applewood Llc

0051359

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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		\$	\$		\$	1
2	3	Housekeeping	Direct Allocation					26,449	2
3	4	Laundry	Direct Allocation					1,020	3
4	6	Repairs & Maintenance	Direct Allocation					31,744	4
5	10	Nursing And Medical Records	Direct Allocation					120,382	5
6	10A	Therapy	Direct Allocation						6
7	21	Clerical & General	Direct Allocation						7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	179,595

Facility Name & ID Number Generations At Applewood Llc

0051359 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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 Applewood Llc

0051359 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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 Applewood Llc

0051359 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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 Applewood Llc

0051359

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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 Applewood Llc

0051359 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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 Applewood Llc

0051359

Report Period Beginning:

01/01/18

Ending:

12/31/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6	Lake Forest Bank		X	Line of Credit				1,060,000		44,773	6									
7	Alloc from Generations Healthcare Network									2,831	7									
8											8									
9	TOTAL Facility Related						\$	1,060,000		\$ 47,604	9									
B. Non-Facility Related*																				
10	Interest Income									(8,420)	10									
11	Alloc from Generations Healthcare Network									(16,205)	11									
12											12									
13											13									
14	TOTAL Non-Facility Related						\$			\$ (24,625)	14									
15	TOTALS (line 9+line14)						\$	1,060,000		\$ 22,979	15									

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

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

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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Generations At Applewood Llc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051359

CONTACT PERSON REGARDING THIS REPORT _____

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 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

(A)	(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>31-22-114-023-0000</u>	<u>Long Term Care Property</u>	\$ <u>14,949.85</u>	\$ <u>14,949.85</u>
2. <u>31-22-114-024-0000</u>	<u>Long Term Care Property</u>	\$ <u>450,178.54</u>	\$ <u>450,178.54</u>
3. <u>31-22-114-025-0000</u>	<u>Long Term Care Property</u>	\$ <u>6,592.84</u>	\$ <u>6,592.84</u>
4. <u>31-22-114-026-0000</u>	<u>Long Term Care Property</u>	\$ <u>18,285.67</u>	\$ <u>18,285.67</u>
5. <u>See Attached</u>	<u>Alloc from Regency Property</u>	\$ <u>899,389.48</u>	\$ <u>215.09</u>
6. <u>See Attached</u>	<u>Alloc from SIR Prop/GHN</u>	\$ <u>137,812.17</u>	\$ <u>4,248.75</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>1,527,208.55</u></u>	\$ <u><u>494,470.74</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? YES NO

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

C. Tax Bills

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2017 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 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Generations At Applewood Llc COUNTY Cook
 FACILITY IDPH LICENSE NUMBER 0051359
 CONTACT PERSON REGARDING THIS REPORT _____
 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 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

	(A) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <u>Tax Applicable to Nursing Home</u>
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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number Generations At Applewood Llc

0051359

Report Period Beginning:

01/01/18 Ending:

12/31/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 34,449 B. General Construction Type: Exterior Brick Frame Steel Stud Number of Stories 1

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.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>191,644</u>	<u>2003</u>	<u>\$ 223,625</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 223,625	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	115	2003	1967	\$ 1,977,857	\$ 82,292	39	\$	\$ (82,292)	\$ 1,977,857	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		2003	17,645		20	133	133	17,212	9
10	Various		2004	30,750		20	1,140	1,140	24,289	10
11	Various		2005	46,763		20	2,338	2,338	31,157	11
12	Various		2006	295,584		20	14,837	14,837	186,694	12
13	Various		2007	154,735		20	2,461	2,461	136,859	13
14	Various		2008	4,000		20	333	333	3,556	14
15	Various		2009	15,494		20	775	775	7,338	15
16	Various		2010	3,500		20	175	175	1,560	16
17	Various		2011	175,218		20	11,132	11,132	83,988	17
18	Various		2012	50,790		20	2,540	2,540	15,730	18
19	Various		2013	45,986		20	2,300	2,300	13,047	19
20	Various		2014	64,708		20	3,235	3,235	14,713	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)							67	
68	Related Party Allocations (Pages 12H & 12I)		70,351	1,528	2,237	709	44,193	68	
69	Financial Statement Depreciation			82,425		(82,425)		69	
70	TOTAL (lines 4 thru 69)		\$ 2,953,381	\$ 166,245		\$ 43,636	\$ (122,609)	\$ 2,558,193	70

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

Facility Name & ID Number Generations At Applewood Llc

0051359

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	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	Totals from Page 12A, Carried Forward		\$ 2,953,381	\$ 166,245		\$ 43,636	\$ (122,609)	\$ 2,558,193	1
2	Asphalt Work	2015	7,281		20	364	364	1,365	2
3	Cooling System (2 Units)	2015	5,245		20	262	262	962	3
4	Carrier Roof-Top Unit	2015	6,825		20	341	341	1,280	4
5	Video Camera & Monitors	2015	2,792		20	279	279	861	5
6	Handrails Installation - All Halls	2015	100,886		20	5,044	5,044	17,235	6
7	Installed Rigid Vinly Flooring	2015	2,731		20	137	137	489	7
8	Installed Wood Tile Flooring In Front Lobby Lounge	2015	3,135		20	157	157	483	8
9	Prime/Paint All Hallways, Install New Drywall	2015	72,380		20	3,619	3,619	11,159	9
10	Wood-Look Tile-Hallways, Nurse Stations, 64 Resident Rooms, Din	2016	361,767		20	18,088	18,088	54,265	10
11	Water Heater	2016	9,594		20	480	480	1,199	11
12	Hvac Air Handler/Condensing Unit	2017	7,866		20	393	393	623	12
13	Booster Heater 6 Gl	2017	2,945		20	147	147	184	13
14	Walk-In Freezer Repair	2017	2,635		20	132	132	187	14
15	Water Heater 120 Gal	2018	3,792		20	174	174	174	15
16	Repaired Break Tank Switches/Pumps/Valves	2018	9,673		20	282	282	282	16
17	Grocery Store Cabinets	2018	6,000		20	400	400	400	17
18	Fabricate Dialysis Room Cabinets	2018	10,000		20	667	667	667	18
19	Fabricate Copy Room Countertop	2018	8,900		20	742	742	742	19
20	Break Room Cabinets	2018	3,850		20	193	193	193	20
21	New Camera System	2018	4,474		20	149	149	149	21
22	Hot Water Heater	2018	13,249		20	166	166	166	22
23	Replace Fire Panel	2018	35,150		20	293	293	293	23
24	Eye/Face Emergency Wash Station	2018	6,180		20	129	129	129	24
25	Infill Two Basement Windows At The North Side Corner	2018	2,500		20	125	125	125	25
26	Wall Protection In Residents Rooms & Rest Rooms	2018	3,672		20	184	184	184	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,646,903	\$ 166,245		\$ 76,583	\$ (89,662)	\$ 2,651,988	34

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

Facility Name & ID Number Generations At Applewood Llc

0051359

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,646,903	\$ 166,245		\$ 76,583	\$ (89,662)	\$ 2,651,988	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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16									16
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,646,903	\$ 166,245		\$ 76,583	\$ (89,662)	\$ 2,651,988	34

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

Facility Name & ID Number Generations At Applewood Llc

0051359

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,646,903	\$ 166,245		\$ 76,583	\$ (89,662)	\$ 2,651,988	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
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,646,903	\$ 166,245		\$ 76,583	\$ (89,662)	\$ 2,651,988	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 12D, Carried Forward		\$ 3,646,903	\$ 166,245		\$ 76,583	\$ (89,662)	\$ 2,651,988	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,646,903	\$ 166,245		\$ 76,583	\$ (89,662)	\$ 2,651,988	34

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

Facility Name & ID Number Generations At Applewood Llc

0051359

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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)		\$	\$		\$	\$	\$	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		\$	\$		\$	\$	\$	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)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Generations At Applewood Llc

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, LLC	2009	9,842	265	39	252	(13)	2,282	3
4	Allocated from S.I.R. Properties/GHN	1993	17,820	566	35	509	(57)	12,983	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Generations Healthcare Network, LLC	1993	4,518	126	20		(126)	4,518	9
10	Allocated from Generations Healthcare Network, LLC	1994	14		20			14	10
11	Allocated from Generations Healthcare Network, LLC	1995	103		20			103	11
12	Allocated from Generations Healthcare Network, LLC	1997	6,942	155	20		(155)	6,942	12
13	Allocated from Generations Healthcare Network, LLC	1999	546		20	27	27	525	13
14	Allocated from Generations Healthcare Network, LLC	1999							14
15	Allocated from Generations Healthcare Network, LLC	2000	644		20	32	32	597	15
16	Allocated from Generations Healthcare Network, LLC	2007	2,071		20	104	104	1,159	16
17	Allocated from Generations Healthcare Network, LLC	2008	5,707	110	20	211	101	3,752	17
18	Allocated from Generations Healthcare Network, LLC	2009	14,180	130	20	709	579	6,554	18
19	Allocated from Generations Healthcare Network, LLC	2011	351	35	20	35		260	19
20	Allocated from Generations Healthcare Network, LLC	2012	1,123	56	20	56		360	20
21	Allocated from Generations Healthcare Network, LLC	2014	157	16	20	8	(8)	36	21
22	Allocated from Generations Healthcare Network, LLC	2016	205	10	20	10		25	22
23	Allocated from Generations Healthcare Network, LLC	2018							23
24									24
25	Allocated from S.I.R. Properties/GHN	2012	1,092	48	20	55	7	328	25
26	Allocated from S.I.R. Properties/GHN	2010	1,075		20	54	54	448	26
27	Allocated from S.I.R. Properties/GHN	2009	1,070		20	53	53	524	27
28	Allocated from S.I.R. Properties/GHN	2007	105	6	20	5	(1)	63	28
29	Allocated from S.I.R. Properties/GHN	2002	71		20	4	4	58	29
30	Allocated from S.I.R. Properties/GHN	1999	2,258		20	113	113	2,202	30
31	Allocated from S.I.R. Properties/GHN	1994	170	4	20		(4)	170	31
32	Allocated from S.I.R. Properties/GHN	1993	289	2	20		(2)	289	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 70,351	\$ 1,528		\$ 2,237	\$ 709	\$ 44,193	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 12H, Carried Forward		\$ 70,351	\$ 1,528		\$ 2,237	\$ 709	\$ 44,193	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
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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)		\$ 70,351	\$ 1,528		\$ 2,237	\$ 709	\$ 44,193	34

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

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	\$ 330,962	\$ 1,377	\$ 33,570	\$ 32,193	10	\$ 187,395	71
72	Current Year Purchases	46,330	32	2,737	2,705	10	2,737	72
73	Fully Depreciated Assets	851,822		261	261	10	851,822	73
74								74
75	TOTALS	\$ 1,229,113	\$ 1,408	\$ 36,568	\$ 35,159		\$ 1,041,953	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 Health	2018	\$ 2,965	\$ 187	\$ 223	\$ 36	5	\$ 1,379	76
77										77
78										78
79										79
80	TOTALS			\$ 2,965	\$ 187	\$ 223	\$ 36		\$ 1,379	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)	\$ 5,102,607	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 167,841	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 113,374	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (54,467)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,695,320	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	Construction in Progress	\$ 14,571,405	92
93			93
94			94
95		\$ 14,571,405	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. _____ /2019 \$ _____

13. _____ /2020 \$ _____

14. _____ /2021 \$ _____

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: \$ 2,921 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>1,889</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>1,889</u>	21

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

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

Facility Name & ID Number Generations At Applewood Llc # 0051359 Report Period Beginning: 01/01/18 Ending: 12/31/18
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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		3	4
		1	2		
		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		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	\$		\$ 241,978	\$		\$ 241,978	1				
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			124,812			124,812	2				
3	Licensed Recreational Therapist		hrs							3				
4	Licensed Physical Therapist	39 - 03	hrs			242,788			242,788	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 prescripts				125,768		125,768	9				
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10				
11	Academic Education		hrs							11				
12	Other (specify):									12				
13	Other (specify):					29,910	12,208		42,118	13				
14	TOTAL			\$		\$ 639,488	\$ 137,976		\$ 777,464	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 Applewood Llc

0051359

Report Period Beginning: 01/01/18

Ending:

12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 5,836	\$ 101,290	1
2	Cash-Patient Deposits	24,239	24,239	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,656,969	2,033,144	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	67,194	67,194	6
7	Other Prepaid Expenses	32,421	32,421	7
8	Accounts Receivable (owners or related parties)		1,004,200	8
9	Other(specify): See Attached Schedule		358,269	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,786,659	\$ 3,620,757	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		223,625	13
14	Buildings, at Historical Cost		3,036,861	14
15	Leasehold Improvements, at Historical Cost	941,814	941,814	15
16	Equipment, at Historical Cost	436,714	436,714	16
17	Accumulated Depreciation (book methods)	(377,083)	(2,577,826)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	2,383,750	14,571,405	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,385,195	\$ 16,632,593	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,171,854	\$ 20,253,350	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 637,167	\$ 637,167	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,289	24,289	28
29	Short-Term Notes Payable	1,060,000	1,060,000	29
30	Accrued Salaries Payable	216,560	216,560	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,722	13,722	31
32	Accrued Real Estate Taxes(Sch.IX-B)		306,250	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,441,605	2,659,572	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,393,343	\$ 4,917,560	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule		11,575,521	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 11,575,521	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,393,343	\$ 16,493,081	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,778,511	\$ 3,760,269	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,171,854	\$ 20,253,350	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,016,739	1
2	Restatements (describe):		2
3	<u>Rounding</u>	4	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,016,743	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(238,232)	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)	\$ (238,232)	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)	\$ 1,778,511	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Generations At Applewood Llc

0051359

Report Period Beginning: 01/01/18

Ending: 12/31/18

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**

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,308,053	1
2	Discounts and Allowances for all Levels	(1,683,746)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,624,307	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,075,967	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,075,967	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	110,741	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,037	19
20	Radiology and X-Ray	816	20
21	Other Medical Services	32,691	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 155,285	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	8,420	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,420	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,863,979	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,343,122	31
32	Health Care	2,787,186	32
33	General Administration	1,505,531	33
B. Capital Expense			
34	Ownership	1,464,255	34
C. Ancillary Expense			
35	Special Cost Centers	777,464	35
36	Provider Participation Fee	224,653	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,102,211	40
41	Income before Income Taxes (line 30 minus line 40)**	(238,232)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (238,232)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,397,380	44
45	Private Pay - Net Inpatient Revenue	502,794	45
46	Medicare - Net Inpatient Revenue	542,362	46
47	Other-(specify) <u>Manage Care</u>	3,029,254	47
48	Other-(specify) <u>Hospice</u>	152,517	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,624,307	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 Applewood Llc

0051359

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	1,636	1,660	\$ 79,367	\$ 47.81	1
2	Assistant Director of Nursing	1,391	1,416	54,283	38.34	2
3	Registered Nurses	12,447	13,526	433,262	32.03	3
4	Licensed Practical Nurses	16,556	17,705	472,168	26.67	4
5	CNAs & Orderlies	62,158	65,497	870,550	13.29	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,509	7,090	128,990	18.19	8
9	Activity Director					9
10	Activity Assistants	9,103	9,816	116,726	11.89	10
11	Social Service Workers	4,855	5,380	93,387	17.36	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,760	19,276	253,402	13.15	15
16	Dishwashers					16
17	Maintenance Workers	2,093	2,353	60,822	25.85	17
18	Housekeepers	13,741	14,888	200,391	13.46	18
19	Laundry	1,200	1,451	20,048	13.82	19
20	Administrator	1,717	2,005	121,878	60.79	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,969	7,215	131,310	18.20	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	4,515	5,207	142,947	27.45	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	2,225	2,392	41,951	17.54	33
34	TOTAL (lines 1 - 33)	164,875	176,877	\$ 3,221,482 *	\$ 18.21	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	\$ 17,946	01-03	35
36	Medical Director	Monthly	47,500	09-03	36
37	Medical Records Consultant	Monthly	2,400	10-03	37
38	Nurse Consultant	Monthly	35,880	10-03	38
39	Pharmacist Consultant	Monthly	6,950	10-03	39
40	Physical Therapy Consultant	230	10,807	10a-03	40
41	Occupational Therapy Consultant	132	9,906	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	95	3,803	10a-03	43
44	Activity Consultant	Monthly	629	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>Specialized Rehab Consultant</u>	Monthly	5,520	10a-03	47
48					48
49	TOTAL (lines 35 - 48)	457	\$ 141,341		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number Generations At Applewood Llc

0051359

Report Period Beginning:

01/01/18

Ending: 12/31/18

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. HCCI \$9,818
- (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. \$ 48,122 Line 10-02
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 224,653
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 benefit on Schedule V. \$ N/A 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? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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 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