

Facility Name & ID Number Generations At Rock Island, Llc

0049866 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	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	27,073	562	9,026	36,661	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,073	562	9,026	36,661	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.75%

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 3,275

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Generations At Rock Island, Llc # 0049866 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 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	209,759	39,259	30,502	279,520		279,520	(3,425)	276,095		1
2	Food Purchase		280,211		280,211	(23,813)	256,398	(495)	255,903		2
3	Housekeeping	176,543	61,757		238,300		238,300	(4,147)	234,153		3
4	Laundry	52,565	22,524		75,089		75,089		75,089		4
5	Heat and Other Utilities			221,290	221,290		221,290	(14,438)	206,852		5
6	Maintenance	37,121	52,042	178,396	267,559		267,559	93,390	360,949		6
7	Other (specify):*							15,367	15,367		7
8	TOTAL General Services	475,988	455,793	430,188	1,361,969	(23,813)	1,338,156	86,251	1,424,408		8
	B. Health Care and Programs										
9	Medical Director			66,000	66,000		66,000		66,000		9
10	Nursing and Medical Records	2,009,782	245,191	1,154,069	3,409,042		3,409,042	(13,726)	3,395,316		10
10a	Therapy	120,416		17,146	137,562		137,562	(5,376)	132,186		10a
11	Activities	112,968	12,101		125,069		125,069		125,069		11
12	Social Services	199,869		1,360	201,229		201,229		201,229		12
13	CNA Training										13
14	Program Transportation			522	522		522		522		14
15	Other (specify):*							5,023	5,023		15
16	TOTAL Health Care and Programs	2,443,035	257,292	1,239,097	3,939,424		3,939,424	(14,079)	3,925,345		16
	C. General Administration										
17	Administrative	100,891		48,972	149,863		149,863	46,022	195,885		17
18	Directors Fees										18
19	Professional Services			242,325	242,325	(52)	242,273	(146,279)	95,994		19
20	Dues, Fees, Subscriptions & Promotions			41,682	41,682		41,682	(16,599)	25,083		20
21	Clerical & General Office Expenses	85,322	27,694	188,693	301,709		301,709	(71,007)	230,702		21
22	Employee Benefits & Payroll Taxes			475,576	475,576	23,813	499,389	(81)	499,307		22
23	Inservice Training & Education										23
24	Travel and Seminar							178	178		24
25	Other Admin. Staff Transportation			6,087	6,087		6,087	11,358	17,445		25
26	Insurance-Prop.Liab.Malpractice			217,946	217,946		217,946	7,273	225,219		26
27	Other (specify):*							24,367	24,367		27
28	TOTAL General Administration	186,213	27,694	1,221,281	1,435,188	23,761	1,458,949	(144,768)	1,314,181		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,105,236	740,779	2,890,566	6,736,581	(52)	6,736,529	(72,596)	6,663,934		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			91,531	91,531		91,531	181,927	273,458			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			154,188	154,188		154,188	31,691	185,879			32
33	Real Estate Taxes					52	52	120,778	120,830			33
34	Rent-Facility & Grounds			483,600	483,600		483,600	(483,600)				34
35	Rent-Equipment & Vehicles			2,801	2,801		2,801	2,682	5,483			35
36	Other (specify):*							22,190	22,190			36
37	TOTAL Ownership			732,120	732,120	52	732,172	(124,332)	607,840			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	263,012	296,251	639,387	1,198,650		1,198,650	(13,902)	1,184,748			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			288,185	288,185		288,185		288,185			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	263,012	296,251	927,572	1,486,835		1,486,835	(13,902)	1,472,933			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,368,248	1,037,030	4,550,258	8,955,536	0	8,955,536	(210,829)	8,744,707			45

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

Facility Name & ID Number Generations At Rock Island, Llc

0049866

Report Period Beginning:

01/01/18

Ending:

12/31/18

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		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	(452)	02		4
5	Telephone, TV & Radio in Resident Rooms	(15,768)	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	(26,647)	30		9
10	Interest and Other Investment Income	(2,291)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(43)	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	(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	(138,196)	21		24
25	Fund Raising, Advertising and Promotional	(8,148)	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	(176,378)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (368,890)		\$	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)	158,061		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 158,061		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (210,829)		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 Rock Island, Llc

ID# 0049866

Report Period Beginning: 01/01/18

Ending: 12/31/18

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Office Expense - Bank Fees	\$ (7,113)	21	1
2	Theft & Damage Loss	(2,495)	21	2
3	Non-allowable Interest	(109,830)	32	3
4	Miscellaneous Income	(33)	21	4
5	PAC Dues	(7,556)	20	5
6	Non-allowable Legal	(19,458)	19	6
7	Collections	(5,502)	21	7
8	Additional R&M	2,806	06	8
9	Bldg Co - Fees	(75)	20	9
10	Bldg Co - Professional Fees	(10,500)	19	10
11	Bldg Co - Capitalized R&M	(10,464)	06	11
12	Bldg Co - Amortization	(2,582)	36	12
13	Prior Period Expense	(3,576)	10	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	(176,378)		49

Generations At Rock Island, Llc

	ID#	<u>0049866</u>
Report Period Beginning:		<u>01/01/18</u>
Ending:		<u>12/31/18</u>

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 Rock Island, Llc# 0049866

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				(2,065)		(1,360)						(3,425)	1
2	Food Purchase	(495)											(495)	2
3	Housekeeping						(4,147)						(4,147)	3
4	Laundry													4
5	Heat and Other Utilities	(15,768)			1,330								(14,438)	5
6	Maintenance	(7,658)	44,151	2,264	55,603		(971)						93,390	6
7	Other (specify):*			778	14,589								15,367	7
8	TOTAL General Services	(23,921)	44,151	3,042	69,457		(6,478)						86,251	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(3,576)		(1,444)	4,999	(2,676)	(11,029)						(13,726)	10
10a	Therapy				(1,222)		(4,154)						(5,376)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			3,776	1,247								5,023	15
16	TOTAL Health Care and Programs	(3,576)		2,332	5,023	(2,676)	(15,183)						(14,079)	16
	C. General Administration													
17	Administrative			(31,379)	77,401								46,022	17
18	Directors Fees													18
19	Professional Services	(29,958)	10,500	(136,205)	9,384								(146,279)	19
20	Fees, Subscriptions & Promotions	(16,746)	75	72									(16,599)	20
21	Clerical & General Office Expenses	(153,339)		82,307	71	(46)							(71,007)	21
22	Employee Benefits & Payroll Taxes					(81)							(81)	22
23	Inservice Training & Education													23
24	Travel and Seminar			178									178	24
25	Other Admin. Staff Transportation			11,358									11,358	25
26	Insurance-Prop.Liab.Malpractice		6,118	991	164								7,273	26
27	Other (specify):*			6,251	18,116								24,367	27
28	TOTAL General Administration	(200,043)	16,693	(66,427)	105,136	(127)							(144,768)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(227,540)	60,844	(61,053)	179,616	(2,802)	(21,661)						(72,596)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Generations At Rock Island, Llc# 0049866

Report Period Beginning:

01/01/18

Ending:

12/31/18

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(26,647)	205,000		3,574								181,927	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(112,121)	159,127	(18,554)	3,239								31,691	32
33	Real Estate Taxes		115,630		5,148								120,778	33
34	Rent-Facility & Grounds		(483,600)										(483,600)	34
35	Rent-Equipment & Vehicles			2,682									2,682	35
36	Other (specify):*	(2,582)	24,772										22,190	36
37	TOTAL Ownership	(141,350)	20,929	(15,872)	11,961								(124,332)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(13,902)							(13,902)	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					(13,902)							(13,902)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(368,890)	81,773	(76,925)	191,577	(16,704)	(21,661)						(210,829)	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: 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 Rental Income	\$ 483,600	Rock Island Real Estate, LLC		\$	\$ (483,600)	1
2	V	20 Fees		Rock Island Real Estate, LLC		75	75	2
3	V	32 Interest Expense & Income	200	Rock Island Real Estate, LLC		159,327	159,127	3
4	V	36 Mortgage Insurance		Rock Island Real Estate, LLC		22,190	22,190	4
5	V	19 Professional Fees		Rock Island Real Estate, LLC		10,500	10,500	5
6	V	26 Property Insurance		Rock Island Real Estate, LLC		6,118	6,118	6
7	V	33 Real Estate Tax	2,088	Rock Island Real Estate, LLC		117,718	115,630	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		205,000	205,000	9
10	V	06 Repairs		Rock Island Real Estate, LLC		44,151	44,151	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 485,888			\$ 567,661	\$ * 81,773	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 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	6 REPAIRS AND MAINT.	\$ 6,468	GENERATIONS HC NETWORK, LLC		\$ 8,732	\$ 2,264	15
16	V	7 EMP. BEN.-GEN. SERV.		GENERATIONS HC NETWORK, LLC		778	778	16
17	V	9 MEDICAL DIRECTOR CONSULTS		GENERATIONS HC NETWORK, LLC				17
18	V	10 NURSING	24,024	GENERATIONS HC NETWORK, LLC		22,580	(1,444)	18
19	V	15 EMP. BEN.-H.C.		GENERATIONS HC NETWORK, LLC		3,776	3,776	19
20	V	17 ADMINISTRATIVE	48,972	GENERATIONS HC NETWORK, LLC		17,593	(31,379)	20
21	V	19 PROFESSIONAL FEES	143,220	GENERATIONS HC NETWORK, LLC		7,015	(136,205)	21
22	V	20 FEES,SUBSCRIPTIONS		GENERATIONS HC NETWORK, LLC		72	72	22
23	V	21 CLERICAL & GENERAL	16,632	GENERATIONS HC NETWORK, LLC		98,939	82,307	23
24	V	24 EDUCATION & SEMINAR		GENERATIONS HC NETWORK, LLC		178	178	24
25	V	25 OTHER ADMIN. STAFF TRANS.		GENERATIONS HC NETWORK, LLC		11,358	11,358	25
26	V	26 INSURANCE		GENERATIONS HC NETWORK, LLC		991	991	26
27	V	27 EMP. BEN.-GEN. ADMIN.		GENERATIONS HC NETWORK, LLC		6,251	6,251	27
28	V	32 INTEREST		GENERATIONS HC NETWORK, LLC		(18,554)	(18,554)	28
29	V	35 AUTO RENTAL		GENERATIONS HC NETWORK, LLC		2,163	2,163	29
30	V	35 EQUIPMENT RENTAL		GENERATIONS HC NETWORK, LLC		519	519	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		\$ 239,316			\$ 162,391	\$ * (76,925)	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 SALARIES	\$ 6,468	GENERATIONS HC NETWORK, LLC	\$ 4,403	\$ (2,065)
16	V	7	EMP. BEN.-DIETARY		GENERATIONS HC NETWORK, LLC	737	737
17	V	10	NURSING SALARIES		GENERATIONS HC NETWORK, LLC	4,999	4,999
18	V	15	EMP. BEN.-NURSING		GENERATIONS HC NETWORK, LLC	832	832
19	V	17	ADMIN./LEGAL SALARIES		GENERATIONS HC NETWORK, LLC	77,401	77,401
20	V	19	FIN. CONSULT./REGL. DIR.		GENERATIONS HC NETWORK, LLC	9,186	9,186
21	V	27	EMP. BEN.-ADMINISTRATIVE		GENERATIONS HC NETWORK, LLC	18,116	18,116
22	V						
23	V						
24	V	10A	DIRECTOR OF SPECIAL REHAB	3,696	GENERATIONS HC NETWORK, LLC	2,474	(1,222)
25	V	15	EMPLOYEE BENEFITS		GENERATIONS HC NETWORK, LLC	415	415
26	V						
27	V	6	MAINTENANCE SALARIES	23,618	GENERATIONS HC NETWORK, LLC	78,452	54,834
28	V	7	EMPLOYEE BENEFITS		GENERATIONS HC NETWORK, LLC	13,852	13,852
29	V						
30	V	5	UTILITIES		GENERATIONS HC NETWORK, LLC	1,330	1,330
31	V	6	REPAIRS AND MAINT.		GENERATIONS HC NETWORK, LLC	769	769
32	V	19	PROFESSIONAL FEES		GENERATIONS HC NETWORK, LLC	198	198
33	V	21	CLERICAL & GENERAL		GENERATIONS HC NETWORK, LLC	71	71
34	V	26	INSURANCE		GENERATIONS HC NETWORK, LLC	164	164
35	V	30	DEPRECIATION		GENERATIONS HC NETWORK, LLC	3,574	3,574
36	V	32	INTEREST		GENERATIONS HC NETWORK, LLC	3,239	3,239
37	V	33	REAL ESTATE TAXES		GENERATIONS HC NETWORK, LLC	5,148	5,148
38	V						
39	Total		\$ 33,782			\$ 225,359	\$ * 191,577

* 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		\$	\$
16	V	10 Nursing and Medical Records	31,045	MAC Rx, LLC		28,370	(2,676)
17	V	10A Therapy		MAC Rx, LLC			
18	V	19 Professional Services		MAC Rx, LLC			
19	V	21 Clerical & General Office Expenses	528	MAC Rx, LLC		483	(46)
20	V	22 Employee Benefits	941	MAC Rx, LLC		860	(81)
21	V	39 Ancillary	161,298	MAC Rx, LLC		147,396	(13,902)
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		\$ 193,813			\$ 177,109	\$ * (16,704)

* 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	\$ 14,203	Big Ten Supply, LLC	100.00%	\$ 12,843	\$ (1,360)
16	V	3 Housekeeping	43,309	Big Ten Supply, LLC	100.00%	39,162	(4,147)
17	V	4 Laundry		Big Ten Supply, LLC	100.00%		
18	V	6 Repairs & Maintenance	10,137	Big Ten Supply, LLC	100.00%	9,166	(971)
19	V	10 Nursing And Medical Records	115,176	Big Ten Supply, LLC	100.00%	104,147	(11,029)
20	V	10A Therapy	43,374	Big Ten Supply, LLC	100.00%	39,221	(4,154)
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		\$ 226,200			\$ 204,539	\$ * (21,661)

* 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, Llc

0049866

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	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 Rock Island, Llc # 0049866 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 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	1.58	3.94%	Alloc. Salary	\$ 11,267	17-7	1
2	Sarah Barrish	Relative	Administrative		See Attached	2.25	4.51%	Alloc. Salary	5,667	17-7	2
3	Louise Bergthold	Shareholder	Administrative	1.13%	See Attached	2.7	4.51%	Alloc. Salary	11,267	17-7	3
4	Thomas Bergthold	Relative	Clerical		See Attached	1.8	4.51%	Alloc. Salary	2,229	21-7	4
5	Andrew Chin	Relative	Clerical		See Attached	1.8	4.51%	Alloc. Salary	3,782	21-7	5
6	Fay Chin	Shareholder	Nursing	1.13%	See Attached	1.8	4.51%	Alloc. Salary	4,999	10-7	6
7	Clark Collins	Relative	Administrative		See Attached	3.2	8.00%	Alloc. Salary	4,001	Var.	7
8	Lynn Ethell	Shareholder	Clerical	1.13%	See Attached	1.35	4.51%	Alloc. Salary	2,283	21-7	8
9	Mike Giannini	Relative	Administrative		See Attached	1.58	3.94%	Alloc. Salary	8,148	17-7	9
10	See Supplemental Schedule								30,119		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	\$ 83,762		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, Llc

0049866 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 Rock Island, Llc

0049866

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	\$ 36,661	\$ 8,732	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	813,429	20	17,260		36,661	778	2
3	9	MEDICAL DIRECTOR CONSUL	PATIENT DAYS	813,429	20			36,661		3
4	10	NURSING	PATIENT DAYS	813,429	20	501,001	501,001	36,661	22,580	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	813,429	20	83,773		36,661	3,776	5
6	17	ADMINISTRATIVE	PATIENT DAYS	813,429	20	390,351	390,351	36,661	17,593	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	813,429	20	155,641		36,661	7,015	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	813,429	20	1,590		36,661	72	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	813,429	20	2,195,251	1,959,905	36,661	98,939	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	813,429	20	3,956		36,661	178	10
11	25	OTHER ADMIN. STAFF TRANS.	PATIENT DAYS	813,429	20	252,011		36,661	11,358	11
12	26	INSURANCE	PATIENT DAYS	813,429	20	21,989		36,661	991	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	813,429	20	138,692		36,661	6,251	13
14	32	INTEREST	PATIENT DAYS	813,429	20	(411,674)		36,661	(18,554)	14
15	35	AUTO RENTAL	PATIENT DAYS	813,429	20	47,983		36,661	2,163	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	813,429	20	11,512		36,661	519	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		\$ 162,391	25

Facility Name & ID Number Generations At Rock Island, Llc

0049866

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	\$ 36,661	\$ 4,403	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	813,429	20	16,359	36,661	737	2
3	10	NURSING SALARIES	PATIENT DAYS	813,429	20	110,913	110,913	4,999	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	813,429	20	18,452	36,661	832	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	813,429	20	1,717,366	1,717,366	77,401	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	813,429	20	203,820	36,661	9,186	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	813,429	20	401,962	36,661	18,116	7
8									8
9									9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	284,688	14	190,531	3,696	2,474	10
11	15	EMPLOYEE BENEFITS	SPECIAL REHAB INC.	284,688	14	31,950	3,696	415	11
12									12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	368,277	19	453,836	63,662	78,452	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	368,277	19	80,131	63,662	13,852	14
15									15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	20	29,526	580	1,330	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	20	17,073	580	769	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	20	4,403	580	198	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	20	1,572	580	71	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	20	3,650	580	164	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	20	79,352	580	3,574	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	20	71,924	580	3,239	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	20	114,307	580	5,148	23
24									24
25	TOTALS					\$ 3,644,817	\$ 2,570,336	\$ 225,359	25

Facility Name & ID Number Generations At Rock Island, Llc

0049866

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					28,370	2
3	10A	Therapy	Direct Allocation						3
4	19	Professional Services	Direct Allocation						4
5	21	Clerical & General Office Expense	Direct Allocation					483	5
6	22	Employee Benefits	Direct Allocation					860	6
7	39	Ancillary	Direct Allocation					147,396	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				\$	\$		\$	177,109

Facility Name & ID Number Generations At Rock Island, Llc

0049866

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

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

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	1	Dietary	Direct Allocation			\$		\$ 12,843	1
2	3	Housekeeping	Direct Allocation					39,162	2
3	4	Laundry	Direct Allocation						3
4	6	Repairs & Maintenance	Direct Allocation					9,166	4
5	10	Nursing And Medical Records	Direct Allocation					104,147	5
6	10A	Therapy	Direct Allocation					39,221	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					\$	\$	204,539	25

Facility Name & ID Number Generations At Rock Island, Llc

0049866

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 Rock Island, Llc

0049866

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 Rock Island, Llc

0049866

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 Rock Island, Llc

0049866

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 Rock Island, Llc

0049866 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 Rock Island, Llc

0049866

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	Centrue Bank		X	Mortgage Payable			\$	\$ 4,382,484		\$ 159,327	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6	Lake Forest Bank & Trust		X	Shareholder Loan				2,930,000			6									
7	Lake Forest Bank & Trust		X	Line of Credit				1,030,000		41,786	7									
8	Lake Forest Bank & Trust		X							2,571	8									
9	TOTAL Facility Related						\$	\$ 8,342,484		\$ 203,684	9									
B. Non-Facility Related*																				
10	Interest Income		X							(2,291)	10									
11	Interest Income - Bldg Co		X							(200)	11									
12	Allocated from Generations Hea	X								(18,554)	12									
13	See Supplemental Schedule									3,239	13									
14	TOTAL Non-Facility Related						\$	\$		\$ (17,806)	14									
15	TOTALS (line 9+line14)						\$	\$ 8,342,484		\$ 185,878	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 22,190 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.)

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Generations At Rock Island, Llc COUNTY Rock Island
 FACILITY IDPH LICENSE NUMBER 0049866
 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>10-341-78-00</u>	<u>Long Term Care Property</u>	\$ <u>110,537.88</u>	\$ <u>110,537.88</u>
2. <u>10-341-79-00</u>	<u>Long Term Care Property</u>	\$ <u>1,574.32</u>	\$ <u>1,574.32</u>
3. <u>10-31-401-046-0000</u>	<u>Allocated from Regency</u>	\$ <u>899,389.48</u>	\$ <u>246.06</u>
4. <u>See Attached</u>	<u>Allocated from S.I.R. Properties</u>	\$ <u>137,812.17</u>	\$ <u>4,860.51</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>1,149,313.85</u></u>	\$ <u><u>117,218.77</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 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 Rock Island, Llc COUNTY Rock Island
 FACILITY IDPH LICENSE NUMBER 0049866
 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.	_____	\$ _____	\$ _____
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.**

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.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>224,770</u>	<u>1997</u>	<u>\$ 420,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 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	\$ 205,000	39	\$ 91,775	\$ (113,225)	\$ 1,962,441	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		2002	10,887		20	396	396	6,363	9
10	Various		2003	5,954		20	216	216	3,261	10
11	Various		2004	9,240		20	336	336	4,886	11
12	Various		2005	48,760		20	2,139	2,139	28,789	12
13	Various		2006	39,068		20	1,421	1,421	18,148	13
14	Various		2008	539,334		20	32,600	32,600	535,979	14
15	Various		2009	265,059		20	15,135	15,135	144,865	15
16	Various		2010	21,670		20	674	674	14,123	16
17	Various		2011	22,411		20	1,277	1,277	9,502	17
18	Various		2012	2,524		20	126	126	810	18
19	Various		2013	51,415		20	2,571	2,571	14,667	19
20	Various		2014	36,562		20	1,828	1,828	8,049	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)	593,071			29,549	29,549	224,597	67
68	Related Party Allocations (Pages 12H & 12I)	80,481	1,749		2,560	811	50,556	68
69	Financial Statement Depreciation		91,531			(91,531)		69
70	TOTAL (lines 4 thru 69)	\$ 5,305,680	\$ 298,280		\$ 182,602	\$ (115,677)	\$ 3,027,036	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		\$ 5,305,680	\$ 298,280		\$ 182,602	\$ (115,677)	\$ 3,027,036	1
2	Exterior Signs	2016			20				2
3	Handrail Repairs At Nurses Station	2016	3,344		20	167	167	502	3
4	Chiller Repairs	2016	2,595		20	130	130	335	4
5	Flooring & Wall Base - 2Nd Floor Corridors	2017	4,929		20	246	246	267	5
6	Repaired A/C	2017	2,996		20	150	150	225	6
7	Colid Cleaner Hvac	2017	2,619		20	131	131	186	7
8	Hall Remodeling Project - Wallcovering	2018	8,132		20	339	339	339	8
9	Replace Fire Pull Stations	2018	2,636		20	77	77	77	9
10	Fence Project	2018	7,010		20	321	321	321	10
11	Paint 102Ptac Units	2018	9,200		20	153	153	153	11
12	New Door	2018	2,648		20	44	44	44	12
13	Landscape Project - 6 New Trees	2018	16,697		20	278	278	278	13
14	Awnings And Frames (4)	2018	4,034		20	50	50	50	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)		\$ 5,372,520	\$ 298,280		\$ 184,690	\$ (113,590)	\$ 3,029,813	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 12B, Carried Forward		\$ 5,372,520	\$ 298,280		\$ 184,690	\$ (113,590)	\$ 3,029,813	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)		\$ 5,372,520	\$ 298,280		\$ 184,690	\$ (113,590)	\$ 3,029,813	34

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

Facility Name & ID Number Generations At Rock Island, Llc

0049866

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		\$ 5,372,520	\$ 298,280		\$ 184,690	\$ (113,590)	\$ 3,029,813	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)		\$ 5,372,520	\$ 298,280		\$ 184,690	\$ (113,590)	\$ 3,029,813	34

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

Facility Name & ID Number Generations At Rock Island, Llc

0049866

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 12D, Carried Forward		\$ 5,372,520	\$ 298,280		\$ 184,690	\$ (113,590)	\$ 3,029,813	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)		\$ 5,372,520	\$ 298,280		\$ 184,690	\$ (113,590)	\$ 3,029,813	34

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

Facility Name & ID Number Generations At Rock Island, Llc

0049866

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	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	2,548	2,548	52,015	9
10	Windows	1998	2,278		20	114	114	1,747	10
11	Walk in Freezer Compressor	2000	2,097		20			2,097	11
12	Electrical Work	2001	1,854		20	93	93	1,406	12
13	Water Heater	2008	6,570		20	329	329	4,935	13
14	Handrails	2008	100,904		20	5,045	5,045	75,675	14
15	Electrical Work-Resident Rooms	2010	7,985		20	399	399	3,192	15
16	Wall Removal - 4th Floor Dining	2010	7,000		20	350	350	3,185	16
17	Outdoor Fence	2010	6,570		20	329	329	2,632	17
18	Kitchen Lighting	2010	8,026		20	401	401	6,022	18
19	Flooring- Carpert and Tile	2011	7,869		20	393	393	2,751	19
20	Fire-Sprinkler Heads	2011	2,790		20	140	140	980	20
21	Outdoor Facility Light sign	2012	10,113		20	506	506	3,036	21
22	Compressor for Walk in Freezer	2012	5,820		20	291	291	1,746	22
23	Dialysis Room- New: Construction, plumbing, HVAC & Electrical	2012	42,518		20	2,126	2,126	12,756	23
24	Nurse Call System	2012	7,800		20	390	390	2,340	24
25	Installed Amtico Flooring on 1st Floor Therapy Room	2013	9,999		20	500	500	2,500	25
26	Installed Cabintery, Countertop Finish & Molding in Physical	2013	12,400		20	620	620	3,100	26
27	Installed Nurse Station	2013	25,000		20	1,250	1,250	6,250	27
28	Installed Elevator Panel	2013	8,000		20	400	400	2,000	28
29	Installed Cabintery	2013	5,000		20	250	250	1,250	29
30	Replacment Windows	2013	9,133		20	457	457	2,284	30
31	Install Flooring & Walls in Break Room & Adjoining Bathroom	2014	4,330		20	217	217	865	31
32	Kitchen Floor Tile	2015	17,653		20	883	883	3,532	32
33	Asphalt & Concrete Work	2015	69,600		20	3,480	3,480	13,920	33
34	TOTAL (lines 1 thru 33)		\$ 432,273	\$		\$ 21,509	\$ 21,509	\$ 212,214	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	\$		\$ 21,509	\$ 21,509	\$ 212,214	1
2	Wall-guards in Hallways	2017	7,541		20	377	377	754	2
3	Installed New Hydrant	2017	5,845		20	292	292	585	3
4	Install new car Sills-Elevator	2017	6,214		20	311	311	621	4
5	Landscaping work, new plants	2017	5,551		20	278	278	555	5
6	Concrete removal & repaving	2017	56,086		20	2,804	2,804	5,609	6
7	Wall A/C 3 & scale	2017	2,975		20	149	149	297	7
8	Replace Handrails/Corner Guards Throughout Facility, As Needed	2017	2,648		20	132	132	265	8
9	Wifi System Upgrade	2018	10,464		20	523	523	523	9
10	Water Heaters	2018	11,500		20	575	575	575	10
11	Cabinets in Therapy Room	2018	14,800		20	740	740	740	11
12	Bath Tile Work	2018	14,061		20	703	703	703	12
13	Painted Therapy Room Walls and Ceiling	2018	23,114		20	1,156	1,156	1,156	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)		\$ 593,071	\$		\$ 29,549	\$	\$ 224,597	34

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

Facility Name & ID Number Generations At Rock Island, Llc

0049866

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	Related Party								1
2	Buildings:								2
3	Allocated from Generations Healthcare Network, LLC	2009	11,259	304	39	289	(15)	2,610	3
4	Allocated from S.I.R. Properties/GHN	1993	20,386	647	35	582	(65)	14,852	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Generations Healthcare Network, LLC	1993	5,168	144	20		(144)	5,168	9
10	Allocated from Generations Healthcare Network, LLC	1994	16		20			16	10
11	Allocated from Generations Healthcare Network, LLC	1995	118		20			118	11
12	Allocated from Generations Healthcare Network, LLC	1997	7,942	178	20		(178)	7,942	12
13	Allocated from Generations Healthcare Network, LLC	1999	624		20	31	31	601	13
14	Allocated from Generations Healthcare Network, LLC	1999							14
15	Allocated from Generations Healthcare Network, LLC	2000	737		20	37	37	683	15
16	Allocated from Generations Healthcare Network, LLC	2007	2,369		20	118	118	1,326	16
17	Allocated from Generations Healthcare Network, LLC	2008	6,528	125	20	241	116	4,292	17
18	Allocated from Generations Healthcare Network, LLC	2009	16,222	148	20	811	663	7,498	18
19	Allocated from Generations Healthcare Network, LLC	2011	401	40	20	40		298	19
20	Allocated from Generations Healthcare Network, LLC	2012	1,284	64	20	64		412	20
21	Allocated from Generations Healthcare Network, LLC	2014	180	18	20	9	(9)	41	21
22	Allocated from Generations Healthcare Network, LLC	2016	234	12	20	12		28	22
23	Allocated from Generations Healthcare Network, LLC	2018							23
24									24
25	Allocated from S.I.R. Properties/GHN	2012	1,249	55	20	62	8	375	25
26	Allocated from S.I.R. Properties/GHN	2010	1,230		20	62	62	513	26
27	Allocated from S.I.R. Properties/GHN	2009	1,224		20	61	61	600	27
28	Allocated from S.I.R. Properties/GHN	2007	121	7	20	6	(1)	72	28
29	Allocated from S.I.R. Properties/GHN	2002	81		20	4	4	67	29
30	Allocated from S.I.R. Properties/GHN	1999	2,583		20	129	129	2,519	30
31	Allocated from S.I.R. Properties/GHN	1994	194	5	20		(5)	194	31
32	Allocated from S.I.R. Properties/GHN	1993	331	2	20		(2)	331	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 80,481	\$ 1,749		\$ 2,560	\$ 811	\$ 50,556	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		\$ 80,481	\$ 1,749		\$ 2,560	\$ 811	\$ 50,556	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
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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)		\$ 80,481	\$ 1,749		\$ 2,560	\$ 811	\$ 50,556	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	\$ 877,750	\$ 1,575	\$ 87,132	\$ 85,557	10	\$ 681,315	71
72	Current Year Purchases	18,291	36	1,082	1,046	10	1,082	72
73	Fully Depreciated Assets	542,347		299	299	10	542,347	73
74								74
75	TOTALS	\$ 1,438,389	\$ 1,611	\$ 88,513	\$ 86,902		\$ 1,224,744	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	\$ 3,392	\$ 214	\$ 255	\$ 41	5	\$ 1,577	76
77										77
78										78
79										79
80	TOTALS			\$ 3,392	\$ 214	\$ 255	\$ 41		\$ 1,577	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)	\$ 7,234,301	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 300,105	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 273,458	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (26,647)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,256,135	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. _____ /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: \$ 3,320 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>2,163</u>	17
18					18
19					19
20					20
21	TOTAL		\$	2,163	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 Rock Island, Llc # 0049866 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		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	39 - 03	hrs		\$			\$	248,536	\$			\$		248,536	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs						43,023						43,023	2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	39 - 03	hrs						245,176						245,176	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							161,298					161,298	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															12
13	Other (specify):				263,012				102,652	134,953					500,617	13
14	TOTAL				\$ 263,012				\$ 639,387	\$ 296,251					\$ 1,198,650	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Generations At Rock Island, Llc

0049866

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	\$ 49,187	\$ 103,944	1
2	Cash-Patient Deposits	42,309	42,309	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,620,920	1,620,920	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,085	18,596	6
7	Other Prepaid Expenses	63,182	63,182	7
8	Accounts Receivable (owners or related parties)	25,034	25,034	8
9	Other(specify): <u>See Attached Schedule</u>	17,941	309,190	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,836,658	\$ 2,183,175	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	846,721	1,507,725	15
16	Equipment, at Historical Cost	619,781	872,153	16
17	Accumulated Depreciation (book methods)	(1,077,385)	(2,612,280)	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>	23,114	82,298	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 412,231	\$ 5,284,503	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,248,889	\$ 7,467,678	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 947,035	\$ 970,149	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	42,394	42,394	28
29	Short-Term Notes Payable	3,960,000	3,960,000	29
30	Accrued Salaries Payable	126,038	126,038	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,038	8,038	31
32	Accrued Real Estate Taxes(Sch.IX-B)		117,718	32
33	Accrued Interest Payable		13,111	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	27,275	52,309	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,110,780	\$ 5,289,757	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,382,484	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)	\$	\$ 4,382,484	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,110,780	\$ 9,672,241	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,861,891)	\$ (2,204,563)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,248,889	\$ 7,467,678	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,088,276)	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,088,277)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,773,614)	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)	\$ (1,773,614)	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)	\$ (2,861,891)	24 *

* This must agree with page 17, line 47.

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	\$ 6,948,244	1
2	Discounts and Allowances for all Levels	(1,696,878)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,251,366	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,694,551	6
7	Oxygen	38,211	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,732,762	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	452	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	147,892	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,072	19
20	Radiology and X-Ray	2,930	20
21	Other Medical Services	38,124	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 195,470	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,291	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,291	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	33	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 33	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,181,922	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,361,969	31
32	Health Care	3,939,424	32
33	General Administration	1,435,188	33
B. Capital Expense			
34	Ownership	732,120	34
C. Ancillary Expense			
35	Special Cost Centers	1,198,650	35
36	Provider Participation Fee	288,185	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,955,536	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,773,614)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,773,614)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,053,824	44
45	Private Pay - Net Inpatient Revenue	85,170	45
46	Medicare - Net Inpatient Revenue	321,253	46
47	Other-(specify) <u>Managed Care, Insurance</u>	543,148	47
48	Other-(specify) <u>Hospice</u>	247,971	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,251,366	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, Llc

0049866

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	1,957	2,086	\$ 92,044	\$ 44.12	1
2	Assistant Director of Nursing	2,027	2,086	75,353	36.12	2
3	Registered Nurses	8,763	9,109	279,512	30.69	3
4	Licensed Practical Nurses	24,253	25,699	617,952	24.05	4
5	CNAs & Orderlies	60,573	63,721	854,623	13.41	5
6	CNA Trainees					6
7	Licensed Therapist	9,329	9,958	263,012	26.41	7
8	Rehab/Therapy Aides	6,994	7,631	120,416	15.78	8
9	Activity Director					9
10	Activity Assistants	8,134	8,798	112,968	12.84	10
11	Social Service Workers	12,049	13,084	198,854	15.20	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,356	21,190	209,759	9.90	15
16	Dishwashers					16
17	Maintenance Workers	2,387	2,500	37,121	14.85	17
18	Housekeepers	17,028	17,601	176,543	10.03	18
19	Laundry	5,321	5,899	52,565	8.91	19
20	Administrator	1,767	2,025	100,891	49.82	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,897	6,333	85,322	13.47	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	4,130	4,467	90,298	20.21	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	246	246	1,015	4.13	33
34	TOTAL (lines 1 - 33)	191,211	202,433	\$ 3,368,248 *	\$ 16.64	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	\$ 30,502	01-03	35
36	Medical Director	Monthly	66,000	09-03	36
37	Medical Records Consultant	Monthly	6,756	10-03	37
38	Nurse Consultant	Monthly	24,024	10-03	38
39	Pharmacist Consultant	Monthly	7,795	10-03	39
40	Physical Therapy Consultant	Monthly	5,936	10a-03	40
41	Occupational Therapy Consultant	Monthly	5,250	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly	2,264	10a-03	43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	1,360	12-03	45
46	Other(specify)				46
47	<u>Specialized Rehab</u>	Monthly	3,696	10A-03	47
48					48
49	TOTAL (lines 35 - 48)		\$ 153,583		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	6,391	\$ 304,895	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	25,733	810,599	10-03	52
53	TOTAL (lines 50 - 52)	32,124	\$ 1,115,494		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	
Matthew Blaha	Administrator	0	\$ 29,825	Workers' Compensation Insurance	\$ 68,674	IDPH License Fee	\$ 1,988	
Elizabeth Webster	Administrator	0	62,451	Unemployment Compensation Insurance	36,511	Advertising: Employee Recruitment	5,404	
Trudy Whittington	Administrator	0	8,614	FICA Taxes	252,966	Health Care Worker Background Check (Indicate # of checks performed 390)	3,903	
				Employee Health Insurance	104,078	Patient Background Checks		
				Employee Meals	23,813	Dues & Subscriptions	9,035	
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Permits	4,681	
				Employee Benefits - Other	12,447	Allocated from Generations Healthcare Netw	72	
				401K Matching Contr.	900			
				Allocated from MAC Rx	(80)	Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 100,891					
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 499,308	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 25,083	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
GHN - Dir. of Administrative Services			\$ 25,872				Out-of-State Travel	\$
GHN - Ancillary Administrative Charges			23,100				In-State Travel	
							Seminar Expense	
							Allocated from Generations Healthcare Netw	178
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 48,972	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 178
C. Professional Services								
Vendor/Payee	Type		Amount					
SIR/Generations HN	Dir. Of Financial Svc		\$ 23,100					
SIR/Generations HN	Dir. Of Information Technology		5,544					
SIR/Generations HN	Dir. Of Regulatory Svc		8,316					
Marcum LLP	Accounting		15,245					
SIR/Generations HN	Bookkeeping		50,820					
SIR/Generations HN	Computer Support		12,012					
Legal Fees	See Attached		23,310					
Personnel Planners	Unemployment Tax Consult		2,977					
Achieve Accreditation	Accreditation		10,075					
HK Payroll	Payroll		4,325					
Pinnacle	Customer Satisfaction		2,897					
See Supplemental Schedule			83,704					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 242,325					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Generations At Rock Island, Llc

0049866

Report Period Beginning:

01/01/18

Ending: 12/31/18

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. HCCI - \$15,111.82
- (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? NA
- (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. \$ 33,955 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. \$ 288,185
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. \$ 23,813 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 452
- (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. Yes
Attach invoices and a summary of services for all architect and appraisal fees