

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0051359

Facility Name: Generations at Applewood

Address: 21020 Kostner Avenue Matteson 60443
Number City Zip Code

County: Cook

Telephone Number: (708) 747-1300 Fax # (708) 747-6282

HFS ID Number:

Date of Initial License for Current Owners: 2/1/2003

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda Telephone Number: (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) _____
(Title) _____

Paid
Preparer

(Signed) _____ * _____ (Date) _____
* Subject to the attached Accountants Consulting Report
(Print Name and Title) _____
(Firm Name & Address) Marcum, LLP
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Generations at Applewood

0051359 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 <u>N/A</u>					
	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	<u>115</u>	Skilled (SNF)	<u>115</u>	<u>42,090</u>	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	<u>115</u>	TOTALS	<u>115</u>	<u>42,090</u>	7

B. Census-For the entire report period.						
	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>16,522</u>	<u>3,038</u>	<u>14,342</u>	<u>33,902</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,522</u>	<u>3,038</u>	<u>14,342</u>	<u>33,902</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.55%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold 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 03/01/2011

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 03/01/2011 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 115 and days of care provided 3,809

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Generations at Applewood # 0051359 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	241,153	25,909	22,499	289,561		289,561	(9,161)	280,400			1
2	Food Purchase		197,537		197,537		197,537	(176)	197,361			2
3	Housekeeping	195,919	29,547		225,466		225,466	(2,164)	223,302			3
4	Laundry	30,871	16,709	59,000	106,580		106,580		106,580			4
5	Heat and Other Utilities			136,265	136,265		136,265	(16,314)	119,951			5
6	Maintenance	59,726	32,898	78,022	170,646		170,646	(10,869)	159,777			6
7	Other (specify):*							1,657	1,657			7
8	TOTAL General Services	527,669	302,600	295,786	1,126,055		1,126,055	(37,027)	1,089,028			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000	714	30,714			9
10	Nursing and Medical Records	1,765,473	217,480	202,250	2,185,203		2,185,203	(18,789)	2,166,414			10
10a	Therapy	196,520		15,896	212,416		212,416	(5,341)	207,075			10a
11	Activities	95,442	4,094	832	100,368		100,368		100,368			11
12	Social Services	48,420		268	48,688		48,688		48,688			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							5,008	5,008			15
16	TOTAL Health Care and Programs	2,105,855	221,574	249,246	2,576,675		2,576,675	(18,408)	2,558,267			16
	C. General Administration											
17	Administrative	121,178		252,151	373,329		373,329	(429,199)	(55,870)			17
18	Directors Fees											18
19	Professional Services			228,242	228,242	(284)	227,958	(147,052)	80,905			19
20	Dues, Fees, Subscriptions & Promotions			58,195	58,195		58,195	(25,124)	33,071			20
21	Clerical & General Office Expenses	212,805	22,780	126,416	362,001		362,001	(16,010)	345,991			21
22	Employee Benefits & Payroll Taxes			527,211	527,211		527,211	(404)	526,807			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,283	2,283		2,283	335	2,618			24
25	Other Admin. Staff Transportation			334	334		334	4,930	5,264			25
26	Insurance-Prop.Liab.Malpractice			144,551	144,551		144,551	1,316	145,867			26
27	Other (specify):*							22,738	22,738			27
28	TOTAL General Administration	333,983	22,780	1,339,383	1,696,146	(284)	1,695,862	(588,472)	1,107,390			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,967,507	546,954	1,884,415	5,398,876	(284)	5,398,592	(643,907)	4,754,685			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			76,005	76,005		76,005	35,824	111,829			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,622	24,622		24,622	(7,769)	16,853			32
33	Real Estate Taxes			458,050	458,050	284	458,334	6,963	465,297			33
34	Rent-Facility & Grounds			718,822	718,822		718,822	(718,822)				34
35	Rent-Equipment & Vehicles			2,565	2,565		2,565	3,642	6,207			35
36	Other (specify):*											36
37	TOTAL Ownership			1,280,064	1,280,064	284	1,280,348	(680,162)	600,186			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		161,628	602,811	764,439		764,439	(11,126)	753,313			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			247,488	247,488		247,488		247,488			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		161,628	850,299	1,011,927		1,011,927	(11,126)	1,000,801			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,967,507	708,582	4,014,778	7,690,867		7,690,867	(1,335,195)	6,355,672			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(17,664)	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	(61,073)	30		9
10	Interest and Other Investment Income	(6,326)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(176)	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	(2,251)	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	(70,184)	21		24
25	Fund Raising, Advertising and Promotional	(19,297)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(786)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(34,302)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (212,059)		\$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,123,136)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,123,136)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,335,195)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Fees	\$ (7,098)	21	1
2	Credit Card Fees	(164)	21	2
3	Theft and Damage Loss	(3,701)	21	3
4	Non-Allowable Interest	(2,750)	32	4
5	Jury Duty Income	(17)	10	5
6	Medical Records Income	(1,376)	10	6
7	Non-Allowable Legal	(7,882)	19	7
8	PAC Dues	(4,743)	20	8
9	Capitalized R&M	(3,820)	06	9
10	Additional R&M	4,071	06	10
11	Building Co - Management Fee	(5,750)	21	11
12	Building Co - Accounting Fee	(800)	19	12
13	Building Co - Bank Service Charge	(22)	21	13
14	Building Co - Filing Fee	(250)	21	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	(34,302)		49

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Generations at Applewood # 0051359 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				(9,140)	(21)							(9,161)	1
2	Food Purchase	(176)											(176)	2
3	Housekeeping					(2,164)							(2,164)	3
4	Laundry													4
5	Heat and Other Utilities	(17,664)			1,350								(16,314)	5
6	Maintenance	251		(12,802)	1,712	(30)							(10,869)	6
7	Other (specify):*				1,657								1,657	7
8	TOTAL General Services	(17,589)		(12,802)	(4,421)	(2,215)							(37,027)	8
	B. Health Care and Programs													
9	Medical Director			714									714	9
10	Nursing and Medical Records	(1,393)		(12,353)	5,049	(9,560)	(532)						(18,789)	10
10a	Therapy				(5,341)								(5,341)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			3,121	1,887								5,008	15
16	TOTAL Health Care and Programs	(1,393)		(8,518)	1,595	(9,560)	(532)						(18,408)	16
	C. General Administration													
17	Administrative			(488,123)	58,924								(429,199)	17
18	Directors Fees													18
19	Professional Services	(8,682)	800	(149,026)	9,856								(147,052)	19
20	Fees, Subscriptions & Promotions	(26,291)		1,167									(25,124)	20
21	Clerical & General Office Expenses	(87,954)	6,022	65,846	86		(10)						(16,010)	21
22	Employee Benefits & Payroll Taxes						(404)						(404)	22
23	Inservice Training & Education													23
24	Travel and Seminar			335									335	24
25	Other Admin. Staff Transportation			4,930									4,930	25
26	Insurance-Prop.Liab.Malpractice			1,197	119								1,316	26
27	Other (specify):*			8,311	14,427								22,738	27
28	TOTAL General Administration	(122,928)	6,822	(555,363)	83,412		(414)						(588,472)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(141,910)	6,822	(576,683)	80,586	(11,776)	(946)						(643,907)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Generations at Applewood # 0051359 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(61,073)	92,650		4,247								35,824	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(9,076)		(2,777)	4,084								(7,769)	32
33	Real Estate Taxes		1,896		5,067								6,963	33
34	Rent-Facility & Grounds		(718,822)										(718,822)	34
35	Rent-Equipment & Vehicles			3,642									3,642	35
36	Other (specify):*													36
37	TOTAL Ownership	(70,149)	(624,276)	865	13,398								(680,162)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(11,126)						(11,126)	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						(11,126)						(11,126)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(212,059)	(617,454)	(575,818)	93,984	(11,776)	(12,072)						(1,335,195)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 718,822	Applewood Property, LLC	100.00%	\$	(718,822)	1
2	V	33	Real Estate Taxes	458,050	Applewood Property, LLC	100.00%	459,946	1,896	2
3	V	21	Management Fee		Applewood Property, LLC	100.00%	5,750	5,750	3
4	V	19	Accounting Fee		Applewood Property, LLC	100.00%	800	800	4
5	V	21	Bank Service Charge		Applewood Property, LLC	100.00%	22	22	5
6	V	21	Filing Fee		Applewood Property, LLC	100.00%	250	250	6
7	V	30	Depreciation		Applewood Property, LLC	100.00%	92,650	92,650	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,176,872			\$ 559,418	\$ * (617,454)	14

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS AND MAINT.	\$ 16,560	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	\$ 3,758	\$ (12,802)	15
16	V	9	MEDICAL DIRECTOR CONSULTS		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	714	714	16
17	V	10	NURSING	35,880	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	23,527	(12,353)	17
18	V	15	EMP. BEN.-H.C.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	3,121	3,121	18
19	V	17	ADMINISTRATIVE	252,151	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	16,179	(235,972)	19
20	V	19	PROFESSIONAL FEES	151,860	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	2,834	(149,026)	20
21	V	20	FEES,SUBSCRIPTIONS		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	1,167	1,167	21
22	V	21	CLERICAL & GENERAL	16,560	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	82,406	65,846	22
23	V	24	EDUCATION & SEMINAR		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	335	335	23
24	V	25	OTHER ADMIN. STAFF TRANS.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	4,930	4,930	24
25	V	26	INSURANCE		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	1,197	1,197	25
26	V	27	EMP. BEN.-GEN. ADMIN.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	8,311	8,311	26
27	V	32	INTEREST		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	(2,777)	(2,777)	27
28	V	35	AUTO RENTAL		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	3,078	3,078	28
29	V	35	EQUIPMENT RENTAL		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	564	564	29
30	V								30
31	V	17	ADMINISTRATIVE	252,151	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%		(252,151)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 725,162			\$ 149,344	\$ * (575,818)	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	\$ 13,800	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	\$ 4,660	\$ (9,140)	15
16	V	7	EMP. BEN.-DIETARY		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	816	816	16
17	V	10	NURSING SALARIES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	5,049	5,049	17
18	V	15	EMP. BEN.-NURSING		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	880	880	18
19	V	17	ADMIN./LEGAL SALARIES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	58,924	58,924	19
20	V	19	FIN. CONSULT./REGL. DIR.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	9,521	9,521	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	14,427	14,427	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	11,040	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	5,699	(5,341)	24
25	V	15	EMPLOYEE BENFITS		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	1,007	1,007	25
26	V								26
27	V	6	MAINTENANCE SALARIES	3,551	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	4,733	1,182	27
28	V	7	EMPLOYEE BENEFITS		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	841	841	28
29	V								29
30	V	5	UTILITIES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	1,350	1,350	30
31	V	6	REPAIRS AND MAINT.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	530	530	31
32	V	19	PROFESSIONAL FEES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	335	335	32
33	V	21	CLERICAL & GENERAL		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	86	86	33
34	V	26	INSURANCE		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	119	119	34
35	V	30	DEPRECIATION		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	4,247	4,247	35
36	V	32	INTEREST		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	4,084	4,084	36
37	V	33	REAL ESTATE TAXES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	5,067	5,067	37
38	V								38
39	Total			\$ 28,391			\$ 122,375	\$ * 93,984	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	\$ 282	Big Ten Supply, LLC	100.00%	\$ 262	\$ (21)	15
16	V	3	Housekeeping	29,539	Big Ten Supply, LLC	100.00%	27,375	(2,164)	16
17	V	6	Repairs & Maintenance	415	Big Ten Supply, LLC	100.00%	384	(30)	17
18	V	10	Nursing And Medical Records	130,489	Big Ten Supply, LLC	100.00%	120,928	(9,560)	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			\$ 160,725			\$ 148,949	\$ * (11,776)	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	10	Nursing and Medical Records	\$ 7,388	MAC Rx, LLC	100.00%	\$ 6,856	\$ (532)	15
16	V	21	Clerical & General Office Expenses	140	MAC Rx, LLC	100.00%	130	(10)	16
17	V	22	Employee Benefits	5,611	MAC Rx, LLC	100.00%	5,207	(404)	17
18	V	39	Ancillary	154,477	MAC Rx, LLC	100.00%	143,352	(11,126)	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			\$ 167,616			\$ 155,544	\$ * (12,072)	39

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

VII. RELATED PARTIES (continued)

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

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

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		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

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ATIED ASSOCIATES	30.60%	ALBANY CARE INC	EVANSTON	APPLEWOOD PROPERTY LLC		BUILDING CO.	1
2	B.G. TRUST	4.00%	BRYN MAWR CARE INC.	CHICAGO	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	2
3	BARRISH GROUP LIMITED PARTNERSHIP	11.35%	GENERATIONS AT COLUMBUS PARK, INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	BRYAN BARRISH TRUST DTD 09/01/2004	11.35%	DECATUR MANOR HEALTHCARE,LLC	DECATUR	LONG TERM CARE LAB, LLC	LINCOLNWOOD	ANCILLARY SUPPLIES	4
5	JOSEPH ABRAMCHIK REVOCABLE TRUST	1.60%	GENERATIONS AT ELMWOOD PARK, INC.	ELMWOOD PARK	OAKTON ARMS	DES PLAINES	ASSISTED LIVING	5
6	L.G. TRUST	4.00%	GENERATIONS AT OAKTON, LLC	DES PLAINES	MAC Rx LLC	DES PLAINES	PHARMACY	6
7	LOUISE BERGTHOLD	1.60%	GREENWOOD CARE, INC.	EVANSTON	GENERATIONS HEALTH NETW	LINCOLNWOOD	CONSULTING CO.	7
8	PATRICIA MCDIARMID	1.60%	WESLEY REHABILITATION CENTER	AUBURN, IN	BIG TEN SUPPLY, LLC	LIBERTYVILLE	SUPPLY CO.	8
9	RALPH GESUALDO	11.35%	GENERATIONS AT NEIGHBORS, LLC	BYRON				9
10	RALPH GESUALDO CHILDREN'S TRUST	11.35%	GENERATIONS AT REGENCY, LLC	NILES				10
11	SARAH BARRISH	1.60%	GENERATIONS AT ROCK ISLAND, LLC	ROCK ISLAND				11
12	THOMAS & STEPHANIE WINTER REVOC TRUST	1.60%	WILSON CARE, INC.	CHICAGO				12
13	UNITED TRUST #1	4.00%						13
14	UNITED TRUST #2	4.00%						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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Generations at Applewood # 0051359 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	Elka Abramchick	Relative	Clerical		See Attached	1.52	4.75%	Alloc Salary	\$ 2,180	21-7	1
2	Joey Abramchik	Owner	Administrative	1.60%	See Attached	1.9	4.75%	Alloc Fees	9,521	17-7	2
3	Bryan Barrish	Relative	Administrative		See Attached	1.9	4.22%	Alloc Salary	9,521	17-7	3
4	Kirsten Schloss	Relative	Maintenance		See Attached	2.38	4.76%	Alloc Salary	4,547	6-7	4
5	Sarah Barrish	Owner	Administrative	1.60%	See Attached	2.38	4.76%	Alloc Salary	5,870	17-7	5
6	Louise Bergthold	Owner	Administrative	1.60%	See Attached	2.86	4.77%	Alloc Salary	9,521	17-7	6
7	Michael Giannini	Relative	Administrative		See Attached	1.67	4.18%	Alloc Salary	8,093	17-7	7
8	Nenita Guzman	Relative	Dietary		See Attached	2.38	4.76%	Alloc Salary	4,660	1-7	8
9	Patricia Mcdiarmid	Owner	Administrative	1.60%	See Attached	2.86	4.77%	Alloc Salary	7,925	17-7	9
10	See Supplemental Schedule								14,781		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	\$ 76,619		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Generations at Applewood # 0051359 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Generations at Applewood # 0051359 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 SIR MGMT.INC & GENERATIONS HC NETW
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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	6	REPAIRS AND MAINT.	PATIENT DAYS	14	\$ 78,945	\$	33,902	\$ 3,758	1
2	9	MEDICAL DIRECTOR CONSULT	PATIENT DAYS	14	15,000		33,902	714	2
3	10	NURSING	PATIENT DAYS	14	494,227		33,902	23,527	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	14	65,558	494,227	33,902	3,121	4
5	17	ADMINISTRATIVE	PATIENT DAYS	14	339,874	339,874	33,902	16,179	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	14	59,533		33,902	2,834	6
7	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	14	24,522		33,902	1,167	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	14	1,731,089	1,318,665	33,902	82,406	8
9	24	EDUCATION & SEMINAR	PATIENT DAYS	14	7,033		33,902	335	9
10	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	14	103,561		33,902	4,930	10
11	26	INSURANCE	PATIENT DAYS	14	25,150		33,902	1,197	11
12	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	14	174,591		33,902	8,311	12
13	32	INTEREST	PATIENT DAYS	14	(58,326)		33,902	(2,777)	13
14	35	AUTO RENTAL	PATIENT DAYS	14	64,663		33,902	3,078	14
15	35	EQUIPMENT RENTAL	PATIENT DAYS	14	11,842		33,902	564	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,137,262	\$ 2,152,767		\$ 149,344	25

Facility Name & ID Number Generations at Applewood# 0051359 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 SIR MGMT.INC & GENERATIONS HC NETW
 Street Address 6840 N. LINCOLN
 City / State / Zip Code LINCOLNWOOD, IL. 60712
 Phone Number (847) 675 -7979
 Fax Number (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1	DIETARY SALARIES	PATIENT DAYS	712,171	14	\$ 97,898	\$ 97,898	33,902	\$ 4,660	1
	2	EMP. BEN.-DIETARY	PATIENT DAYS	712,171	14	17,139		33,902	816	2
	3	NURSING SALARIES	PATIENT DAYS	712,171	14	106,059	106,059	33,902	5,049	3
	4	EMP. BEN.-NURSING	PATIENT DAYS	712,171	14	18,488		33,902	880	4
	5	ADMIN./LEGAL SALARIES	PATIENT DAYS	712,171	14	1,237,797	1,115,138	33,902	58,924	5
	6	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	712,171	14	200,000		33,902	9,521	6
	7	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	712,171	14	303,056		33,902	14,427	7
	8									8
	9									9
	10	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	322,920	13	166,688	166,688	11,040	5,699	10
	11	EMPLOYEE BENFITS	SPECIAL REHAB INC.	322,920	13	29,469		11,040	1,007	11
	12									12
	13	MAINTENANCE SALARIES	MAINTENANCE INC.	335,151	14	446,742	446,742	3,551	4,733	13
	14	EMPLOYEE BENEFITS	MAINTENANCE INC.	335,151	14	79,358		3,551	841	14
	15									15
	16	UTILITIES	ALLOCATED SQ FT	12,878	14	28,358		613	1,350	16
	17	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,878	14	11,129		613	530	17
	18	PROFESSIONAL FEES	ALLOCATED SQ FT	12,878	14	7,038		613	335	18
	19	CLERICAL & GENERAL	ALLOCATED SQ FT	12,878	14	1,812		613	86	19
	20	INSURANCE	ALLOCATED SQ FT	12,878	14	2,507		613	119	20
	21	DEPRECIATION	ALLOCATED SQ FT	12,878	14	89,214		613	4,247	21
	22	INTEREST	ALLOCATED SQ FT	12,878	14	85,804		613	4,084	22
	23	REAL ESTATE TAXES	ALLOCATED SQ FT	12,878	14	106,445		613	5,067	23
	24									24
	25	TOTALS				\$ 3,035,001	\$ 1,932,526		\$ 122,375	25

Facility Name & ID Number Generations at Applewood # 0051359 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Big Ten Supply, LLC
Street Address 15632 West Sprucewood Lane
City / State / Zip Code Libertyville, IL 60048
Phone Number (312)502-5882
Fax Number (847)816-3425

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1	Dietary	Direct Allocation			\$	\$		\$ 262	1
	2	Housekeeping	Direct Allocation						27,375	2
	3	Repairs & Maintenance	Direct Allocation						384	3
	4	Nursing And Medical Records	Direct Allocation						120,928	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				\$	\$		\$ 148,949	25

Facility Name & ID Number Generations at Applewood # 0051359 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing And Medical Records	Direct Allocation			\$	\$		\$ 6,856	1
2	21	Clerical & General Office Expense	Direct Allocation						130	2
3	22	Employee Benefits	Direct Allocation						5,207	3
4	39	Ancillary	Direct Allocation						143,352	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					\$	\$		\$ 155,544	25

Facility Name & ID Number Generations at Applewood # 0051359 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Generations at Applewood # 0051359 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Generations at Applewood # 0051359 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number

Fax Number

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Generations at Applewood # 0051359 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Generations at Applewood # 0051359 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5					-								5
	Working Capital												
6	Lake Forest Bank		X	Line of Credit				825,000				21,872	6
7	Alloc from SIR Mgmt/Generations HC											4,084	7
8					-								8
9	TOTAL Facility Related						\$	825,000				\$ 25,956	9
	B. Non-Facility Related*												
10	Interest Income		X									(6,326)	10
11	Alloc from SIR Mgmt/Generations HC											(2,777)	11
12													12
13					-								13
14	TOTAL Non-Facility Related						\$					\$ (9,103)	14
15	TOTALS (line 9+line14)						\$	825,000				\$ 16,852	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NoneLine # N/A

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
6													6
7	TOTAL Long-Term												7
	Working Capital												
8							\$					\$	8
9													9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital												14
	B. Non-Facility Related*												
15							\$					\$	15
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related												20

* 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	215,676	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	450,367	2
3. Under or (over) accrual (line 2 minus line 1).			\$	234,691	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	222,650	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	284	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.					
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	457,625	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011364,1008			
		2012342,1969			
		2013398,28810			
		2014431,35111			
		2015445,30012			
2016 Accrual: 445,300 x 1.05 = \$467,565 - 244,915 (Estimated 1st Installment of 2016 tax) = \$222,650					
2015 real estate taxes are 445,300, however the facility paid the 2nd installment of the 2015 and the 1st installment of the 2016 in 2016.					
The total actually paid in 2016 was \$452,972. This is the reason for the variance on line 7 above, and line 33 on page 4.					
Allocated from SIR Management/Generations HC Network, LLC: \$5,067					
			FOR BHF USE ONLY		
		13	FROM R. E. TAX STATEMENT FOR 2015 \$		13
		14	PLUS APPEAL COST FROM LINE 5 \$		14
		15	LESS REFUND FROM LINE 6 \$		15
		16	AMOUNT TO USE FOR RATE CALCULATION \$		16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAMEGenerations at ApplewoodCOUNTYCook

FACILITY IDPH LICENSE NUMBER0051359

CONTACT PERSON REGARDING THIS REPORTSteve Lavenda

TELEPHONE(847) 236-6300FAX #:(847) 236-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

A. Square Feet:

34,449

B. General Construction Type:

ExteriorBrick

FrameSteel Stud

Number of Stories

1

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	191,644	2003	\$223,625	1
2					2
3	TOTALS	191,644		\$223,625	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	115		2003	1967	\$ 1,977,857	\$ 92,650	39	\$	\$ (92,650)	\$ 1,977,857	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		2003		17,643		20	199	199	16,877	9
10	Various		2004		30,750		20	1,139	1,139	22,009	10
11	Various		2005		46,763		20	2,338	2,338	26,480	11
12	Various		2006		295,584		20	14,935	14,935	156,922	12
13	Various		2007		154,735		20	6,065	6,065	130,735	13
14	Various		2008		4,000		20	333	333	2,889	14
15	Various		2009		15,494		20	775	775	5,789	15
16	Various		2010		3,500		20	175	175	1,210	16
17	Various		2011		175,218		20	11,132	11,132	61,723	17
18	Various		2012		50,790		20	2,540	2,540	10,651	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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Generations at Applewood

0051359

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		98,600	2,537		3,674	1,137	51,268	68
69	Financial Statement Depreciation			76,005			(76,005)		69
70	TOTAL (lines 4 thru 69)		\$ 2,870,933	\$ 171,192		\$ 43,306	\$ (127,886)	\$ 2,464,409	70

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

Facility Name & ID Number Generations at Applewood

0051359

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,870,933	\$ 171,192		\$ 43,306	\$ (127,886)	\$ 2,464,409	1
2	Security Camera	2013	6,630		20	332	332	1,298	2
3	Front Door Alarm System	2013	6,025		20	301	301	1,130	3
4	Roof Top Air Conditioner	2013	8,100		20	405	405	1,485	4
5	Nurse Call System	2013	21,451		20	1,073	1,073	3,843	5
6	Asphalt In Parking Lot And Drives	2013	3,780		20	189	189	693	6
7	Condensing Unit	2014	3,525		20	176	176	529	7
8	Dvr - Security System	2014	3,119		20	156	156	429	8
9	Wi-Fi Wiring Upgrade	2014	12,230		20	612	612	1,682	9
10	Concrete Sidewalk & Asphalt Work	2014	17,416		20	871	871	2,322	10
11	Sprinkler System (263 Heads)	2014	15,345		20	767	767	1,854	11
12	Annuciator Panel For Fire Alarm	2014	3,845		20	192	192	465	12
13	Carpeting - Various Offices	2014	9,228		20	461	461	923	13
14	Asphalt Work	2015	7,281		20	364	364	637	14
15	Cooling System (2 Units)	2015	5,245		20	262	262	437	15
16	Carrier Roof-Top Unit	2015	6,825		20	341	341	597	16
17	Video Camera & Monitors	2015	2,792		20	279	279	302	17
18	Handrails Installation - All Halls	2015	100,886		20	5,044	5,044	7,146	18
19	Installed Rigid Vinly Flooring	2015	2,731		20	137	137	216	19
20	Installed Wood Tile Flooring In Front Lobby Lounge	2015	3,135		20	157	157	170	20
21	Prime/Paint All Hallways, Install New Drywall	2015	72,380		20	3,619	3,619	3,921	21
22	Re-Tile Hallways, Nurse Stations, 64 Resident Rooms, Dining Room	2016	361,767		20	18,088	18,088	18,088	22
23	Water Heater	2016	9,594		20	240	240	240	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,554,264	\$ 171,192		\$ 77,372	\$ (93,820)	\$ 2,512,816	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$3,554,264	\$171,192		\$77,372	\$(93,820)	\$2,512,816	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$3,554,264	\$171,192		\$77,372	\$(93,820)	\$2,512,816	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12C, Carried Forward		\$ 3,554,264	\$ 171,192		\$ 77,372	\$ (93,820)	\$ 2,512,816	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 3,554,264	\$ 171,192		\$ 77,372	\$ (93,820)	\$ 2,512,816	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,554,264	\$ 171,192		\$ 77,372	\$ (93,820)	\$ 2,512,816	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,554,264	\$ 171,192		\$ 77,372	\$ (93,820)	\$ 2,512,816	34

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

Facility Name & ID Number Generations at Applewood

0051359

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Generations at Applewood

0051359

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Generations at Applewood

0051359

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	<u>Allocated from SIR Management/Generations HC Network</u>	2009	23,800	610	39	610		4,297	3
4	<u>Allocated from SIR Properties - SIR Management</u>	1993	21,547	684	35	616	(68)	14,467	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	<u>Allocated from SIR Management/Generations HC Network</u>	1993	5,463	152	20		(152)	5,463	9
10	<u>Allocated from SIR Management/Generations HC Network</u>	1994	17		20			17	10
11	<u>Allocated from SIR Management/Generations HC Network</u>	1995	125		20			125	11
12	<u>Allocated from SIR Management/Generations HC Network</u>	1997	8,394		20	409	409	8,253	12
13	<u>Allocated from SIR Management/Generations HC Network</u>	1999	660		20	33	33	569	13
14	<u>Allocated from SIR Management/Generations HC Network</u>	2000	779		20	39	39	645	14
15	<u>Allocated from SIR Management/Generations HC Network</u>	2007	2,504		20	125	125	1,151	15
16	<u>Allocated from SIR Management/Generations HC Network</u>	2008	6,900	690	20	435	(255)	3,847	16
17	<u>Allocated from SIR Management/Generations HC Network</u>	2009	17,146	157	20	857	700	6,211	17
18	<u>Allocated from SIR Management/Generations HC Network</u>	2011	424	42	20	42		230	18
19	<u>Allocated from SIR Management/Generations HC Network</u>	2012	1,357	68	20	68		300	19
20	<u>Allocated from SIR Management/Generations HC Network</u>	2014	190	19	20	10	(9)	25	20
21	<u>Allocated from SIR Management/Generations HC Network</u>	2016	248	5	20	5		5	21
22									22
23	<u>Allocated from SIR Properties - SIR Management</u>	2012	1,320	66	20	66		264	23
24	<u>Allocated from SIR Properties - SIR Management</u>	2010	1,300		20	65	65	412	24
25	<u>Allocated from SIR Properties - SIR Management</u>	2009	1,294	29	20	65	36	505	25
26	<u>Allocated from SIR Properties - SIR Management</u>	2007	377	8	20	19	11	189	26
27	<u>Allocated from SIR Properties - SIR Management</u>	2002	85		20	4	4	62	27
28	<u>Allocated from SIR Properties - SIR Management</u>	1999	2,730		20	137	137	2,389	28
29	<u>Allocated from SIR Properties - SIR Management</u>	1998	1,305		20	65	65	1,207	29
30	<u>Allocated from SIR Properties - SIR Management</u>	1997	81		20	4	4	81	30
31	<u>Allocated from SIR Properties - SIR Management</u>	1994	205	5	20		(5)	205	31
32	<u>Allocated from SIR Properties - SIR Management</u>	1993	349	2	20		(2)	349	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 98,600	\$ 2,537		\$ 3,674	\$ 1,137	\$ 51,268	34

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

Facility Name & ID Number Generations at Applewood

0051359

Report Period Beginning:

01/01/16

Ending:

12/31/16

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		\$ 98,600	\$ 2,537		\$ 3,674	\$ 1,137	\$ 51,268	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 98,600	\$ 2,537		\$ 3,674	\$ 1,137	\$ 51,268	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	\$ 302,008	\$ 1,547	\$ 30,720	\$ 29,173	10	\$ 136,496	71
72	Current Year Purchases	46,756	16	3,576	3,560	10	3,576	72
73	Fully Depreciated Assets	840,037		15	15	10	840,037	73
74								74
75	TOTALS	\$ 1,188,801	\$ 1,563	\$ 34,311	\$ 32,748		\$ 980,110	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 SIR Mgmt/Gener	2016	\$ 1,673	\$ 146	\$ 145	\$ (1)	5	\$ 1,287	76
77										77
78										78
79										79
80	TOTALS			\$ 1,673	\$ 146	\$ 145	\$ (1)		\$ 1,287	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)	\$ 4,968,363	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 172,901	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 111,828	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (61,073)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,494,213	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	Additions/Alteration Project	\$ 1,906,967	92
93			93
94			94
95		\$ 1,906,967	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.

YESNO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease

9. Option to Buy: YES NO Terms: *

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

15. Is Movable equipment rental included in building rental?

YESNO
16. Rental Amount for movable equipment: \$3,129Description: 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	Allocated from SIR Mgmt/Generations HC		\$	\$3,078	17
18					18
19					19
20					20
21	TOTAL		\$-	\$3,078	21

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.	/2017	\$
13.	/2018	\$
14.	/2019	\$

* 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.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 234,377	\$		\$ 234,377	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			100,618			100,618	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			230,468			230,468	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				154,989		154,989	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					37,348	6,639		43,987	13
14	TOTAL			\$		\$ 602,811	\$ 161,628		\$ 764,439	14

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 45,561	\$ 225,419	1
2	Cash-Patient Deposits	24,679	24,679	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	993,222	1,276,211	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	58,492	58,492	6
7	Other Prepaid Expenses	1,156	1,156	7
8	Accounts Receivable (owners or related parties)		2,763,444	8
9	Other(specify): <u>See Attached Schedule</u>	25	74,992	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,123,135	\$ 4,424,393	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		223,625	13
14	Buildings, at Historical Cost		3,036,861	14
15	Leasehold Improvements, at Historical Cost	834,990	834,990	15
16	Equipment, at Historical Cost	384,143	384,143	16
17	Accumulated Depreciation (book methods)	(216,672)	(2,242,458)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	1,906,967	1,331,967	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,909,428	\$ 3,569,128	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,032,563	\$ 7,993,521	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 187,540	\$ 187,540	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,704	24,704	28
29	Short-Term Notes Payable	825,000	825,000	29
30	Accrued Salaries Payable	193,527	193,527	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,319	11,319	31
32	Accrued Real Estate Taxes(Sch.IX-B)		222,650	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	584,589	884,589	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,826,679	\$ 2,349,329	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,826,679	\$ 2,349,329	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,205,884	\$ 5,644,192	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,032,563	\$ 7,993,521	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,278,569	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,278,569	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	77,315	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	(150,000)	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)	\$ (72,685)	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)	\$ 2,205,884	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Generations at Applewood

0051359

Report Period Beginning: 01/01/16

Ending: 12/31/16

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,452,977	1
2	Discounts and Allowances for all Levels	(1,801,930)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,651,047	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,913,132	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,913,132	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	136,766	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,601	19
20	Radiology and X-Ray	2,638	20
21	Other Medical Services	42,279	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 196,284	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,326	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,326	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,393	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,393	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,768,182	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,126,055	31
32	Health Care	2,576,675	32
33	General Administration	1,696,146	33
	B. Capital Expense		
34	Ownership	1,280,064	34
	C. Ancillary Expense		
35	Special Cost Centers	764,439	35
36	Provider Participation Fee	247,488	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,690,867	40
41	Income before Income Taxes (line 30 minus line 40)**	77,315	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 77,315	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,778,574	44
45	Private Pay - Net Inpatient Revenue	552,957	45
46	Medicare - Net Inpatient Revenue	578,474	46
47	Other-(specify) <u>Managed Care/Insurance</u>	1,406,305	47
48	Other-(specify) <u>Hospice</u>	334,737	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,651,047	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.

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	1,208	1,286	\$ 55,820	\$ 43.41	1
2	Assistant Director of Nursing	1,926	2,100	75,055	35.74	2
3	Registered Nurses	11,643	12,791	419,788	32.82	3
4	Licensed Practical Nurses	15,912	16,746	397,210	23.72	4
5	CNAs & Orderlies	56,473	58,694	661,203	11.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,867	9,868	196,520	19.91	8
9	Activity Director					9
10	Activity Assistants	8,936	9,454	95,442	10.10	10
11	Social Service Workers	2,909	3,223	48,420	15.02	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,409	20,222	241,153	11.93	15
16	Dishwashers					16
17	Maintenance Workers	2,026	2,289	59,726	26.09	17
18	Housekeepers	15,751	17,161	195,919	11.42	18
19	Laundry	2,022	2,273	30,871	13.58	19
20	Administrator	1,880	2,091	121,178	57.95	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,671	12,294	212,805	17.31	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,047	5,506	156,397	28.40	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	164,680	175,998	\$ 2,967,507 *	\$ 16.86	34

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	\$ 22,499	01-03	35
36	Medical Director	Monthly	30,000	09-03	36
37	Medical Records Consultant	Monthly	2,400	10-03	37
38	Nurse Consultant	Monthly	35,880	10-03	38
39	Pharmacist Consultant	Monthly	2,078	10-03	39
40	Physical Therapy Consultant	55	2,558	10a-03	40
41	Occupational Therapy Consultant	24	1,818	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	12	480	10a-03	43
44	Activity Consultant	Monthly	832	11-03	44
45	Social Service Consultant	Monthly	268	12-03	45
46	Other(specify)				46
47	Specialized Rehab	Monthly	11,040	10a-03	47
48					48
49	TOTAL (lines 35 - 48)	91	\$ 109,853		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	10	\$ 268	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	6,675	161,624	10-03	52
53	TOTAL (lines 50 - 52)	6,685	\$ 161,892		53

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

** See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. IL Council on LTC \$14,373
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period? Yes
10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 45,596 Line 10-02
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 247,488
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? None Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees