

		FOR BHF USE					

LL1

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: 0040410

Facility Name: Generations at Elmwood Park

Address: 7733 West Grand Ave Elmwood Park 60707
Number City Zip Code

County: Cook

Telephone Number: (708) 452-9200 Fax # (708) 452-9294

HFS ID Number:

Date of Initial License for Current Owners: 4/1/1993

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 Elmwood Park

0040410 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

N/A

1	2	3	4	
Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	245	245	89,670	1
2	Skilled (SNF)			2
3	Skilled Pediatric (SNF/PED)			3
4	Intermediate (ICF)			4
5	Intermediate/DD			5
6	Sheltered Care (SC)			6
7	ICF/DD 16 or Less			7
245	TOTALS	245	89,670	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	27,555	316	33,905	61,776	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,555	316	33,905	61,776	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.89%

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 4/1/1993

J. Was the facility purchased or leased after January 1, 1978?

YES

☒

Date 4/1/1993

NO

☐

K. Was the facility certified for Medicare during the reporting year?

YES

☒

NO

☐

If YES, enter number

of beds certified

245

and days of care provided

6,091

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒

NO

☐

Tax Year: 12/31/2016

Fiscal Year: 12/31/2016

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

Facility Name & ID Number Generations at Elmwood Park # 0040410 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	378,848	42,920	66,316	488,084		488,084	(21,318)	466,766			1
2	Food Purchase		350,862		350,862	(46,819)	304,043	(18)	304,025			2
3	Housekeeping	340,429	91,932		432,361		432,361	(6,656)	425,705			3
4	Laundry	110,791	50,457		161,248		161,248	(135)	161,113			4
5	Heat and Other Utilities			290,136	290,136		290,136	(17,162)	272,974			5
6	Maintenance	80,085	64,941	278,568	423,594		423,594	(26,901)	396,693			6
7	Other (specify):*							15,772	15,772			7
8	TOTAL General Services	910,153	601,112	635,020	2,146,285	(46,819)	2,099,466	(56,419)	2,043,048			8
	B. Health Care and Programs											
9	Medical Director			44,400	44,400		44,400	1,301	45,701			9
10	Nursing and Medical Records	4,568,832	771,259	86,022	5,426,113		5,426,113	(131,704)	5,294,409			10
10a	Therapy	351,685	161,578	36,276	549,539		549,539	(22,628)	526,911			10a
11	Activities	114,410	2,920	2,496	119,826		119,826		119,826			11
12	Social Services	196,949		4,898	201,847		201,847		201,847			12
13	CNA Training											13
14	Program Transportation			19,385	19,385		19,385		19,385			14
15	Other (specify):*							9,437	9,437			15
16	TOTAL Health Care and Programs	5,231,876	935,757	193,477	6,361,110		6,361,110	(143,594)	6,217,516			16
	C. General Administration											
17	Administrative	200,580		938,016	1,138,596		1,138,596	(801,164)	337,432			17
18	Directors Fees											18
19	Professional Services			397,620	397,620	(3,018)	394,602	(265,304)	129,298			19
20	Dues, Fees, Subscriptions & Promotions			71,410	71,410		71,410	(33,518)	37,892			20
21	Clerical & General Office Expenses	355,474	44,253	212,629	612,356		612,356	(21,900)	590,456			21
22	Employee Benefits & Payroll Taxes			1,179,947	1,179,947	46,819	1,226,766		1,226,766			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,642	3,642		3,642	610	4,252			24
25	Other Admin. Staff Transportation			3,088	3,088		3,088	8,983	12,071			25
26	Insurance-Prop.Liab.Malpractice			297,183	297,183		297,183	12,463	309,646			26
27	Other (specify):*							41,433	41,433			27
28	TOTAL General Administration	556,054	44,253	3,103,535	3,703,842	43,801	3,747,643	(1,058,396)	2,689,246			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,698,083	1,581,122	3,932,032	12,211,237	(3,018)	12,208,219	(1,258,409)	10,949,810			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			125,824	125,824		125,824	669,950	795,774			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			115,614	115,614		115,614	514,190	629,804			32
33	Real Estate Taxes					3,018	3,018	585,301	588,319			33
34	Rent-Facility & Grounds			1,944,000	1,944,000		1,944,000	(1,944,000)				34
35	Rent-Equipment & Vehicles			5,469	5,469		5,469	6,636	12,105			35
36	Other (specify):*							128,413	128,413			36
37	TOTAL Ownership			2,190,907	2,190,907	3,018	2,193,925	(39,510)	2,154,415			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	922,645	581,329	1,045,300	2,549,274		2,549,274	(22,842)	2,526,432			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			483,688	483,688		483,688		483,688			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	922,645	581,329	1,528,988	3,032,962		3,032,962	(22,842)	3,010,120			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,620,728	2,162,451	7,651,927	17,435,106		17,435,106	(1,320,762)	16,114,344			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	(19,622)	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	205,450	30		9
10	Interest and Other Investment Income	(8,416)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(18)	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	(8,951)	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	(129,431)	21		24
25	Fund Raising, Advertising and Promotional	(18,129)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(142,591)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (121,708)		\$	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)	(1,199,054)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,199,054)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,320,762)		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

Report Period Beginning:

Ending:

ID#0040410

01/01/16

12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Purchased Services - VA	\$ (55,819)	10	1
2	Bank Fees	(6,810)	21	2
3	Theft & Damage	(609)	21	3
4	Legal Fees-Collections	(10,241)	19	4
5	Additional R&M	3,343	06	5
6	PAC Dues	(8,240)	20	6
7	Non Allowable Legal Fees	(1,406)	19	7
8	PPA - Medical Supply	(14,292)	10	8
9	Non- allowable fees-Chamber of Commerce	(325)	20	9
10	Bldg. Co. - Filing Fees	(500)	21	10
11	Bldg. Co. - Amortization	(7,896)	36	11
12	Bldg. Co. - Office Expense	(60)	21	12
13	Bldg. Co. - Professional Fees	(8,783)	19	13
14	Non-Allowable Interest	(4,200)	32	14
15	Jury Duty	(75)	10	15
16	Non-Allowable RE Taxes	(1,332)	33	16
17	Building Co. R&M	(2,750)	06	17
18	Capitalized R&M	(22,596)	06	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	(142,591)		49

ID#0040410

Report Period Beginning:01/01/16

Ending:12/31/16

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 Elmwood Park # 0040410 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				(20,908)	(410)							(21,318)	1
2	Food Purchase	(18)											(18)	2
3	Housekeeping					(6,656)							(6,656)	3
4	Laundry					(135)							(135)	4
5	Heat and Other Utilities	(19,622)			2,460								(17,162)	5
6	Maintenance	(22,003)	2,750	(28,432)	21,053	(269)							(26,901)	6
7	Other (specify):*				15,772								15,772	7
8	TOTAL General Services	(41,643)	2,750	(28,432)	18,377	(7,471)							(56,419)	8
	B. Health Care and Programs													
9	Medical Director			1,301									1,301	9
10	Nursing and Medical Records	(70,186)		(33,569)	9,200	(26,966)	(10,183)						(131,704)	10
10a	Therapy				(11,379)	(11,249)							(22,628)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			5,687	3,750								9,437	15
16	TOTAL Health Care and Programs	(70,186)		(26,581)	1,571	(38,215)	(10,183)						(143,594)	16
	C. General Administration													
17	Administrative			(908,534)	107,370								(801,164)	17
18	Directors Fees													18
19	Professional Services	(20,430)	8,783	(271,616)	17,959								(265,304)	19
20	Fees, Subscriptions & Promotions	(35,645)		2,127									(33,518)	20
21	Clerical & General Office Expenses	(137,410)	560	114,880	157		(87)						(21,900)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			610									610	24
25	Other Admin. Staff Transportation			8,983									8,983	25
26	Insurance-Prop.Liab.Malpractice		10,064	2,182	217								12,463	26
27	Other (specify):*			15,145	26,288								41,433	27
28	TOTAL General Administration	(193,485)	19,407	(1,036,223)	151,991		(87)						(1,058,396)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(305,314)	22,157	(1,091,236)	171,939	(45,686)	(10,270)						(1,258,409)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Generations at Elmwood Park # 0040410 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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	205,450	456,762		7,738								669,950	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(12,616)	524,423	(5,059)	7,442								514,190	32
33	Real Estate Taxes	(1,332)	577,400		9,233								585,301	33
34	Rent-Facility & Grounds		(1,944,000)										(1,944,000)	34
35	Rent-Equipment & Vehicles			6,636									6,636	35
36	Other (specify):*	(7,896)	136,309										128,413	36
37	TOTAL Ownership	183,606	(249,106)	1,577	24,413								(39,510)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(22,842)						(22,842)	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						(22,842)						(22,842)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(121,708)	(226,949)	(1,089,659)	196,352	(45,686)	(33,113)						(1,320,762)	45

VII. RELATED PARTIES

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

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

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 1,944,000	Elmwood Property, LLC	100.00%	\$	(1,944,000)	1
2	V	21	Filing Fees		Elmwood Property, LLC	100.00%	500	500	2
3	V	32	Interest	251	Elmwood Property, LLC	100.00%	524,674	524,423	3
4	V	36	Mortgage Insurance		Elmwood Property, LLC	100.00%	128,413	128,413	4
5	V	21	Office Expense		Elmwood Property, LLC	100.00%	60	60	5
6	V	19	Professional Fees		Elmwood Property, LLC	100.00%	8,783	8,783	6
7	V	33	Real Estate	15,000	Elmwood Property, LLC	100.00%	592,400	577,400	7
8	V	06	Repairs		Elmwood Property, LLC	100.00%	2,750	2,750	8
9	V	36	Amortization of HUD Fees		Elmwood Property, LLC	100.00%	7,896	7,896	9
10	V	30	Depreciation		Elmwood Property, LLC	100.00%	456,762	456,762	10
11	V	26	Property Insurance		Elmwood Property, LLC	100.00%	10,064	10,064	11
12	V								12
13	V								13
14	Total			\$ 1,959,251			\$ 1,732,302	\$ * (226,949)	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.	\$ 35,280	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	\$ 6,848	\$ (28,432)	15
16	V	9	MEDICAL DIRECTOR CONSULTS		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	1,301	1,301	16
17	V	10	NURSING	76,440	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	42,871	(33,569)	17
18	V	15	EMP. BEN.-H.C.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	5,687	5,687	18
19	V	17	ADMINISTRATIVE	938,016	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	29,482	(908,534)	19
20	V	19	PROFESSIONAL FEES	276,780	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	5,164	(271,616)	20
21	V	20	FEES,SUBSCRIPTIONS		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	2,127	2,127	21
22	V	21	CLERICAL & GENERAL	35,280	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	150,160	114,880	22
23	V	24	EDUCATION & SEMINAR		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	610	610	23
24	V	25	OTHER ADMIN. STAFF TRANS.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	8,983	8,983	24
25	V	26	INSURANCE		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	2,182	2,182	25
26	V	27	EMP. BEN.-GEN. ADMIN.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	15,145	15,145	26
27	V	32	INTEREST		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	(5,059)	(5,059)	27
28	V	35	AUTO RENTAL		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	5,609	5,609	28
29	V	35	EQUIPMENT RENTAL		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	1,027	1,027	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			\$ 1,361,796			\$ 272,137	\$ * (1,089,659)	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	\$ 29,400	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	\$ 8,492	\$ (20,908)	15
16	V	7	EMP. BEN.-DIETARY		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	1,487	1,487	16
17	V	10	NURSING SALARIES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	9,200	9,200	17
18	V	15	EMP. BEN.-NURSING		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	1,604	1,604	18
19	V	17	ADMIN./LEGAL SALARIES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	107,370	107,370	19
20	V	19	FIN. CONSULT./REGL. DIR.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	17,349	17,349	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	26,288	26,288	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	23,520	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	12,141	(11,379)	24
25	V	15	EMPLOYEE BENFITS		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	2,146	2,146	25
26	V								26
27	V	6	MAINTENANCE SALARIES	60,332	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	80,419	20,088	27
28	V	7	EMPLOYEE BENEFITS		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	14,285	14,285	28
29	V								29
30	V	5	UTILITIES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	2,460	2,460	30
31	V	6	REPAIRS AND MAINT.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	965	965	31
32	V	19	PROFESSIONAL FEES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	610	610	32
33	V	21	CLERICAL & GENERAL		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	157	157	33
34	V	26	INSURANCE		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	217	217	34
35	V	30	DEPRECIATION		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	7,738	7,738	35
36	V	32	INTEREST		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	7,442	7,442	36
37	V	33	REAL ESTATE TAXES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	9,233	9,233	37
38	V								38
39	Total			\$ 113,252			\$ 309,604	\$ * 196,352	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.

☒ X

 YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$ 5,600	Big Ten Supply, LLC	100.00%	\$ 5,190	\$ (410)	15
16	V	3	Housekeeping	90,851	Big Ten Supply, LLC	100.00%	84,195	(6,656)	16
17	V	4	Laundry	1,843	Big Ten Supply, LLC	100.00%	1,708	(135)	17
18	V	6	Repairs & Maintenance	3,677	Big Ten Supply, LLC	100.00%	3,407	(269)	18
19	V	10	Nursing And Medical Records	368,056	Big Ten Supply, LLC	100.00%	341,090	(26,966)	19
20	V	10A	Therapy	153,536	Big Ten Supply, LLC	100.00%	142,287	(11,249)	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			\$ 623,562			\$ 577,876	\$ * (45,686)	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	\$ 141,395	MAC Rx, LLC	100.00%	\$ 131,211	\$ (10,183)	15
16	V	21	Clerical & General Office Expenses	1,205	MAC Rx, LLC	100.00%	1,118	(87)	16
17	V	22	Employee Benefits		MAC Rx, LLC	100.00%			17
18	V	39	Ancillary	317,162	MAC Rx, LLC	100.00%	294,320	(22,842)	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			\$ 459,761			\$ 426,649	\$ * (33,113)	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	ADAM VALES TRUST	2.88%	ALBANY CARE INC	EVANSTON	ELMWOOD PROPERTY, LLC	LINCOLNWOOD	BUILDING CO.	1
2	BRYAN BARRISH TRUST DTD 09/01/2004	14.25%	GENERATIONS AT APPLEWOOD, LLC	MATTESON	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	2
3	CELESTE GIANNINI TRUST DTD 3/13/00	17.75%	BRYN MAWR CARE INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	DANIEL ROTHNER TRUST	2.88%	GENERATIONS AT COLUMBUS PARK, INC	CHICAGO	LONG TERM CARE LAB, LLC	LINCOLNWOOD	ANCILLARY SUPPLIES	4
5	DENNIS TOSSI	0.82%	DECATUR MANOR HEALTHCARE,LLC	DECATUR	OAKTON ARMS	DES PLAINES	ASSISTED LIVING	5
6	GALE ROTHNER	9.47%	GREENWOOD CARE, INC.	EVANSTON	MAC Rx LLC	DES PLAINES	PHARMACY	6
7	HARVEY SCOTT	0.82%	GENERATIONS AT NEIGHBORS, LLC	BYRON	GENERATIONS HEALTH NETW	LINCOLNWOOD	CONSULTING CO.	7
8	JEFF ORAVEC	0.41%	GENERATIONS AT ROCK ISLAND, LLC	ROCK ISLAND	BIG TEN SUPPLY, LLC	LIBERTYVILLE	SUPPLY CO.	8
9	JOEY ABRAMCHIK	2.06%	WILSON CARE, INC.	CHICAGO				9
10	JULIANA R. BARRISH TRUST DTD 1/26/93	14.25%	WESLEY REHABILITATION CENTER	AUBURN, IN				10
11	KATHRYN VALES TRUST	2.88%	GENERATIONS AT OAKTON, LLC	DES PLAINES				11
12	KIMBERLY RICHMAN TRUST	2.88%	GENERATIONS REGENCY LLC	NILES				12
13	LORI BARRISH	2.06%						13
14	LOUISE BERGTHOLD	4.94%						14
15	MELISSA ROTHNER TRUST	2.88%						15
16	MICHAEL R GIANNINI TRUST DTD 3/13/00	11.57%						16
17	RACHEL ROTHNER TRUST	2.88%						17
18	THOMAS WINTER	1.44%						18
19	WILLIAM ROTHNER TRUST	2.88%						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 Elmwood Park # 0040410 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	Bryan Barrish	Relative	Administrative		See Attached	3.47	7.71%	Alloc. Salary	\$ 17,349	17-7	1
2	Michael Giannini	Relative	Administrative		See Attached	3.04	7.60%	Alloc. Salary	14,746	17-7	2
3	Nenita Guzman	Relative	Dietary		See Attached	4.34	8.68%	Alloc. Salary	8,492	1-7	3
4	Sarah Barrish	Relative	Administrative		See Attached	4.34	8.68%	Alloc. Salary	10,696	17-7	4
5	Kirsten Schloss	Relative	Maintenance		See Attached	4.34	8.68%	Alloc. Salary	8,285	6-7	5
6	Jeff Oravec	Shareholder	Administrative	0.41%	See Attached	3.47	8.68%	Alloc. Salary	12,133	17-7	6
7	Tom Winter	Shareholder	Administrative	1.44%	See Attached	5.2	8.67%	Alloc. Salary	17,349	17-7	7
8	Louise Bergthold	Shareholder	Administrative	4.94%	See Attached	5.2	8.67%	Alloc. Salary	17,349	17-7	8
9	Joey Abramchik	Shareholder	Administrative	2.06%	See Attached	3.47	8.68%	Alloc. Salary	17,349	17-7	9
10											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	\$ 123,748		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 Elmwood Park # 0040410 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 Elmwood Park # 0040410 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	712,171	14	\$ 78,945	\$	61,776	\$ 6,848	1
2	9	MEDICAL DIRECTOR CONSULT	PATIENT DAYS	712,171	14	15,000		61,776	1,301	2
3	10	NURSING	PATIENT DAYS	712,171	14	494,227		61,776	42,871	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	712,171	14	65,558	494,227	61,776	5,687	4
5	17	ADMINISTRATIVE	PATIENT DAYS	712,171	14	339,874	339,874	61,776	29,482	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	712,171	14	59,533		61,776	5,164	6
7	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	712,171	14	24,522		61,776	2,127	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	712,171	14	1,731,089	1,318,665	61,776	150,160	8
9	24	EDUCATION & SEMINAR	PATIENT DAYS	712,171	14	7,033		61,776	610	9
10	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	712,171	14	103,561		61,776	8,983	10
11	26	INSURANCE	PATIENT DAYS	712,171	14	25,150		61,776	2,182	11
12	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	712,171	14	174,591		61,776	15,145	12
13	32	INTEREST	PATIENT DAYS	712,171	14	(58,326)		61,776	(5,059)	13
14	35	AUTO RENTAL	PATIENT DAYS	712,171	14	64,663		61,776	5,609	14
15	35	EQUIPMENT RENTAL	PATIENT DAYS	712,171	14	11,842		61,776	1,027	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		\$ 272,137	25

Facility Name & ID Number Generations at Elmwood Park # 0040410 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	1	DIETARY SALARIES	PATIENT DAYS	712,171	14	\$ 97,898	\$ 97,898	61,776	\$ 8,492	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	712,171	14	17,139		61,776	1,487	2
3	10	NURSING SALARIES	PATIENT DAYS	712,171	14	106,059	106,059	61,776	9,200	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	712,171	14	18,488		61,776	1,604	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	712,171	14	1,237,797	1,115,138	61,776	107,370	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	712,171	14	200,000		61,776	17,349	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	712,171	14	303,056		61,776	26,288	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	322,920	13	166,688	166,688	23,520	12,141	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	322,920	13	29,469		23,520	2,146	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	335,151	14	446,742	446,742	60,332	80,419	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	335,151	14	79,358		60,332	14,285	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,878	14	28,358		1,117	2,460	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,878	14	11,129		1,117	965	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,878	14	7,038		1,117	610	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,878	14	1,812		1,117	157	19
20	26	INSURANCE	ALLOCATED SQ FT	12,878	14	2,507		1,117	217	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,878	14	89,214		1,117	7,738	21
22	32	INTEREST	ALLOCATED SQ FT	12,878	14	85,804		1,117	7,442	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,878	14	106,445		1,117	9,233	23
24										24
25	TOTALS					\$ 3,035,001	\$ 1,932,526		\$ 309,603	25

Facility Name & ID Number Generations at Elmwood Park # 0040410 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			\$	\$		5,190	1
	2	Housekeeping	Direct Allocation						84,195	2
	3	Laundry	Direct Allocation						1,708	3
	4	Repairs & Maintenance	Direct Allocation						3,407	4
	5	Nursing And Medical Records	Direct Allocation						341,090	5
	6	Therapy	Direct Allocation						142,287	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				\$	\$		577,876	25

Facility Name & ID Number Generations at Elmwood Park # 0040410 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	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	10	Nursing And Medical Records	Direct Allocation			\$	\$		\$ 131,211	1
2	21	Clerical & General Office Expense	Direct Allocation						1,118	2
3	22	Employee Benefits	Direct Allocation							3
4	39	Ancillary	Direct Allocation						294,320	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					\$	\$		\$ 426,649	25

Facility Name & ID Number Generations at Elmwood Park # 0040410 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 Elmwood Park # 0040410 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 Elmwood Park # 0040410 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 Elmwood Park # 0040410 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 Elmwood Park # 0040410 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	First Merit Bank		X	Mortgage			\$	16,003,885			\$	524,674	1	
2													2	
3													3	
4													4	
5					-								5	
	Working Capital													
6	Wintrust		X	Line of Credit				2,530,000				111,414	6	
7	Shareholder/Member loans	X						170,000					7	
8	See Supplemental Schedule				-							7,442	8	
9	TOTAL Facility Related						\$	18,703,885				\$	643,530	9
	B. Non-Facility Related*													
10	Interest Income		X									(7,286)	10	
11	Interest Income	X										(1,130)	11	
12	Interest Income-Bldg. Co.		X									(251)	12	
13	Allocated from SIR/Generation	X			-							(5,059)	13	
14	TOTAL Non-Facility Related						\$					\$	(13,726)	14
15	TOTALS (line 9+line14)						\$	18,703,885				\$	629,804	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 128,413 Line # 36

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

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

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	Alloc from SIR/Generation HN	X					\$	\$			\$ 7,442	8	
9												9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital										7,442	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.) SEE ACCOUNTANTS' COMPILATION REPORT

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Generations at Elmwood Park

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

0040410

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-6300

FAX #:

(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. <u>12-25-323-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>154,346.24</u>	\$ <u>154,346.24</u>
2. <u>12-25-323-004-0000</u>	<u>Long Term Care Property</u>	\$ <u>154,195.93</u>	\$ <u>154,195.93</u>
3. <u>12-25-323-005-0000</u>	<u>Long Term Care Property</u>	\$ <u>241,368.12</u>	\$ <u>241,368.12</u>
4. <u>12-25-324-001-0000</u>	<u>Long Term Care Property</u>	\$ <u>6,944.35</u>	\$ <u>6,944.35</u>
5. <u>12-25-324-002-0000</u>	<u>Long Term Care Property</u>	\$ <u>5,975.89</u>	\$ <u>5,975.89</u>
6. <u>12-25-323-002-0000</u>	<u>Long Term Care Property</u>	\$ <u>1,331.96</u>	\$ <u></u>
7. <u>10-31-401-046-0000</u>	<u>Allocation from Regency Property</u>	\$ <u>890,957.88</u>	\$ <u>938.94</u>
8. <u>See Attached</u>	<u>Allocation from SIR/Generations HN</u>	\$ <u>123,678.12</u>	\$ <u>8,401.29</u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u><u>1,578,798.49</u></u>	\$ <u><u>572,170.76</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 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.**

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 NAME	<u>Generations at Elmwood Park</u>	COUNTY	<u>Cook</u>
---------------	------------------------------------	--------	-------------

FACILITY IDPH LICENSE NUMBER 0040410

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

46,565

B. General Construction Type:

Exterior

Brick

Frame

Number of Stories

4

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:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	Facility			1993		\$ 624,991	1
2				1998		100,000	2
3	TOTALS					\$ 724,991	3

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	245			1975	\$ 10,419,509	\$ 456,762	35	\$ 297,700	\$ (159,062)	\$ 6,654,849	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	129,203		20			129,189	9
10	Various			1994	49,738		20			49,732	10
11	Various			1995	167,102		20			167,099	11
12	Various			1996	136,090		20	4,331	4,331	136,082	12
13	Various			1997	16,180		20	809	809	15,813	13
14	Various			1998	158,155		20	6,538	6,538	147,614	14
15	Various			1999	121,088		20	6,054	6,054	106,148	15
16	Various			2000	67,583		20	3,379	3,379	55,627	16
17	Various			2001	107,654		20	5,383	5,383	83,958	17
18	Various			2002	113,214		20	305	305	113,011	18
19	Various			2003	145,109		20	6,702	6,702	101,584	19
20	Various			2004	124,757		20	6,521	6,521	77,986	20
21	Various			2005	84,119		20	3,706	3,706	53,871	21
22	Various			2006	127,687		20	6,208	6,208	71,173	22
23	Various			2007	117,180		20	6,773	6,773	65,052	23
24	Various			2008	56,513		20	2,826	2,826	24,160	24
25	Various			2009	123,292		20	7,159	7,159	53,567	25
26	Various			2010	254,770		20	12,739	12,739	84,779	26
27	Various			2011	11,899		20	1,046	1,046	6,165	27
28	Various			2012	49,934		20	2,497	2,497	11,473	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		3,380,077			169,004	169,004	1,254,144	67
68	Related Party Allocations (Pages 12H & 12I)		193,380	4,624		6,694	2,070	107,123	68
69	Financial Statement Depreciation			125,824			(125,824)		69
70	TOTAL (lines 4 thru 69)		\$ 16,154,234	\$ 587,210		\$ 556,373	\$ (30,837)	\$ 9,570,199	70

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

Facility Name & ID Number Generations at Elmwood Park

0040410

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		\$ 16,154,234	\$ 587,210		\$ 556,373	\$ (30,837)	\$ 9,570,199	1
2	Ffi-Fire Stop System	2013	5,990		20	300	300	1,123	2
3	Elevator Upgrades	2013	17,081		20	854	854	2,989	3
4	Hvac Repairs	2013	2,512		20	126	126	492	4
5	Nurse Call System - 1St Floor	2014	8,999		20	450	450	1,275	5
6	Doors And Installation	2014	10,188		20	509	509	1,316	6
7	Dietary Cabinets	2014	2,700		20	135	135	349	7
8	Doors (32)	2014	9,436		20	472	472	1,180	8
9	Replace Sumb & Balance Tray Strainers On Bac Cooling Tower	2014	3,321		20	166	166	443	9
10	Alley Ramp Repairs	2014	3,000		20	150	150	388	10
11	Replace Bearings On Bac Tower	2014	4,579		20	229	229	553	11
12	Circuit Breaker In Control Room	2014	2,500		20	125	125	260	12
13	Metal Door & Frame	2015	2,690		20	269	269	448	13
14	Grade Parking Lot	2015	6,200		20	310	310	543	14
15	New Carpet - Admissions Office	2015	4,933		20	247	247	267	15
16	Misc Handrail Repairs	2015	3,397		20	170	170	184	16
17	Repair Walk-In Freezer	2015	2,696		20	135	135	168	17
18	Fire Alarm Jockey Pump & Valve	2015	2,596		20	130	130	141	18
19	Hilo Bronze Mixing Valve	2016	2,754		20	126	126	126	19
20	Steel Door (2)-Kitchen	2016	6,398		20	80	80	80	20
21	Repalced Gas Valves	2016	2,507		20	125	125	125	21
22	Replaced Flame Safe Guard Controller	2016	2,574		20	129	129	129	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)		\$ 16,261,284	\$ 587,210		\$ 561,609	\$ (25,601)	\$ 9,582,777	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		\$16,261,284	\$587,210		\$561,609	\$(25,601)	\$9,582,777	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)		\$16,261,284	\$587,210		\$561,609	\$(25,601)	\$9,582,777	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		\$16,261,284	\$587,210		\$561,609	\$(25,601)	\$9,582,777	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)		\$16,261,284	\$587,210		\$561,609	\$(25,601)	\$9,582,777	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 16,261,284	\$ 587,210		\$ 561,609	\$ (25,601)	\$ 9,582,777	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)		\$ 16,261,284	\$ 587,210		\$ 561,609	\$ (25,601)	\$ 9,582,777	34

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

Facility Name & ID Number Generations at Elmwood Park

0040410

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	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	HVAC Project	2008	1,560,000		20	78,000	78,000	702,000	9
10	Painting	2008	130,000		20	6,500	6,500	58,500	10
11	Elevator Cab	2008	43,612		20	2,181	2,181	19,626	11
12	Hand Rails	2008	15,105		20	755	755	6,797	12
13	Nurse Station	2008	112,920		20	5,646	5,646	50,814	13
14	Side Entry Hub	2008	8,245		20	412	412	3,710	14
15	Nurses Stations	2009	37,640		20	1,882	1,882	15,056	15
16	Window Treatement	2009	6,775		20	339	339	2,710	16
17	1st Floor Tile	2009	126,810		20	6,341	6,341	50,725	17
18	Resident Bathroom/Dayroom - Ceiling, Fixtures, Tiles, Paint	2009	202,085		20	10,104	10,104	80,834	18
19	Wiring	2009	10,034		20	502	502	4,014	19
20	Windows	2009	3,200		20	160	160	1,280	20
21	Lower Level Mall-Ceiling, Plumbing, Doors, Paint	2009	201,263		20	10,063	10,063	80,505	21
22	Painting	2009	15,000		20	750	750	6,000	22
23	Lower Level Mall-Drawings for Construction Permit	2009	9,000		20	450	450	3,600	23
24	2nd Floor Work	2009	23,400		20	1,170	1,170	9,360	24
25	2nd Floor Ceiling	2009	16,070		20	804	804	6,429	25
26	Sprinkler System Renovation	2009	11,017		20	551	551	4,407	26
27	Chair rail in dining Room	2009	11,312		20	566	566	4,525	27
28	Handrails - Floors 2,3,4	2009	44,652		20	2,233	2,233	17,861	28
29	Wallbase - Floors 2,3,4	2009	15,324		20	766	766	6,129	29
30	Tuckpointing	2011	61,030		20	3,052	3,052	18,310	30
31	Generator Project	2011	56,363		20	2,818	2,818	16,909	31
32	Replace, Resurface, & Restripe Asphalt Pavement	2013	13,500		20	675	675	2,700	32
33	Smoke Detectors	2013	3,229		20	161	161	645	33
34	TOTAL (lines 1 thru 33)		\$ 2,737,586	\$		\$ 136,879	\$ 136,879	\$ 1,173,444	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 12F, Carried Forward		\$ 2,737,586	\$		\$ 136,879	\$ 136,879	\$ 1,173,444	1
2 3rd Floor Tile Flooring	2014	143,845		20	7,192	7,192	21,577	2
3 2nd Floor Tile Flooring	2014	140,927		20	7,046	7,046	21,139	3
4 Lintel Replacement	2014	66,530		20	3,327	3,327	9,980	4
5 Elevator Grab-Bar & Signage	2015	3,063		20	153	153	306	5
6 Windows - Entire Facility	2015	124,906		20	6,245	6,245	12,490	6
7 Flooring - 4th Floor	2015	140,928		20	7,046	7,046	14,092	7
8 Installed electrical wiring from basement/1st FL/Resident Rooms	2016	4,500		20	225	225	225	8
9 Exterior Signage	2016	8,757		20	438	438	438	9
10 Walk-in Freezer-work	2016	6,285		20	314	314	314	10
11 Fan coil	2016	2,750		20	138	138	138	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)		\$ 3,380,077	\$		\$ 169,004	\$ 169,004	\$ 1,254,144	34

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

Facility Name & ID Number Generations at Elmwood Park

0040410

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	Allocated from SIR Management/Generations HN	2009	43,369	1,112	39	1,112		7,830	3
4	Allocated from SIR Properties - SIR Mgmt/Generations HN	1993	39,263	1,246	35	1,122	(124)	26,362	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from SIR Management/Generations HN	1993	9,954	277	20		(277)	9,954	9
10	Allocated from SIR Management/Generations HN	1994	31					31	10
11	Allocated from SIR Management/Generations HN	1995	228					227	11
12	Allocated from SIR Management/Generations HN	1997	15,296		20	746	746	15,039	12
13	Allocated from SIR Management/Generations HN	1999	1,203		20	60	60	1,037	13
14	Allocated from SIR Management/Generations HN	1999	13,707		20			13,707	14
15	Allocated from SIR Management/Generations HN	2000	1,420		20	71	71	1,175	15
16	Allocated from SIR Management/Generations HN	2007	4,562		20	228	228	2,097	16
17	Allocated from SIR Management/Generations HN	2008	12,573	1,257	20	793	(464)	7,009	17
18	Allocated from SIR Management/Generations HN	2009	31,243	286	20	1,562	1,276	11,317	18
19	Allocated from SIR Management/Generations HN	2011	773	77	20	77		419	19
20	Allocated from SIR Management/Generations HN	2012	2,474	124	20	124		546	20
21	Allocated from SIR Management/Generations HN	2014	347	35	20	17	(18)	45	21
22	Allocated from SIR Management/Generations HN	2016	451	9	20	9		9	22
23									23
24	Allocated from SIR Properties - SIR Mgmt/Generations HN	2012	2,405	121	20	120	(1)	482	24
25	Allocated from SIR Properties - SIR Mgmt/Generations HN	2010	2,369			118	118	750	25
26	Allocated from SIR Properties - SIR Mgmt/Generations HN	2009	2,357	53	20	118	65	919	26
27	Allocated from SIR Properties - SIR Mgmt/Generations HN	2007	687	14	20	34	20	344	27
28	Allocated from SIR Properties - SIR Mgmt/Generations HN	2002	156		20	8	8	113	28
29	Allocated from SIR Properties - SIR Mgmt/Generations HN	1999	4,975		20	249	249	4,353	29
30	Allocated from SIR Properties - SIR Mgmt/Generations HN	1998	2,378		20	119	119	2,199	30
31	Allocated from SIR Properties - SIR Mgmt/Generations HN	1997	148		20	7	7	148	31
32	Allocated from SIR Properties - SIR Mgmt/Generations HN	1994	374	10	20		(10)	374	32
33	Allocated from SIR Properties - SIR Mgmt/Generations HN	1993	637	3	20		(3)	637	33
34	TOTAL (lines 1 thru 33)		\$ 193,380	\$ 4,624		\$ 6,694	\$ 2,070	\$ 107,123	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 12H, Carried Forward		\$193,380	\$4,624		\$6,694	\$2,070	\$107,123	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)		\$193,380	\$4,624		\$6,694	\$2,070	\$107,123	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	\$2,545,288	\$2,819	\$230,103	\$227,284	10	\$1,591,613	71
72	Current Year Purchases	42,980	29	3,770	3,741	10	3,770	72
73	Fully Depreciated Assets	723,670		28	28	10	723,670	73
74								74
75	TOTALS	\$3,311,938	\$2,848	\$233,902	\$231,054		\$2,319,053	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/Generations]	2016	\$3,049	\$266	\$263	\$ (3)	5	\$2,346	76
77										77
78										78
79										79
80	TOTALS			\$3,049	\$266	\$263	\$ (3)		\$2,346	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$20,301,262	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$590,324	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$795,774	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$205,450	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$11,904,176	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

☐ YES☐ NO
- If NO, see instructions.

		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?

☐ YES☐ NO
16. Rental Amount for movable equipment: \$6,496Description: 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/Generations HN		\$	\$5,609	17
18					18
19					19
20					20
21	TOTAL		\$-	\$5,609	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.)

		1	2	3	4	5	6	7	8	
	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	\$		\$ 240,662	\$		\$ 240,662	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			226,374			226,374	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			314,759			314,759	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				317,162		317,162	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental			922,645		263,505	264,167		1,450,317	13
14	TOTAL			\$ 922,645		\$ 1,045,300	\$ 581,329		\$ 2,549,274	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	\$ 18,523	\$ 113,733	1
2	Cash-Patient Deposits	57,843	57,843	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,378,723	4,378,723	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	55,910	100,200	6
7	Other Prepaid Expenses	15,287	15,287	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		955,163	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,526,286	\$ 5,620,949	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		882,991	13
14	Buildings, at Historical Cost		10,419,509	14
15	Leasehold Improvements, at Historical Cost	1,106,825	4,482,124	15
16	Equipment, at Historical Cost	2,876,959	4,241,036	16
17	Accumulated Depreciation (book methods)	(2,822,790)	(11,132,938)	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):		422,106	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,160,994	\$ 9,314,828	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,687,280	\$ 14,935,777	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 838,097	\$ 838,097	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	57,843	57,843	28
29	Short-Term Notes Payable	2,700,000	2,700,000	29
30	Accrued Salaries Payable	499,865	499,865	30
31	Accrued Taxes Payable (excluding real estate taxes)	30,934	30,934	31
32	Accrued Real Estate Taxes(Sch.IX-B)		592,400	32
33	Accrued Interest Payable		43,344	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	229,439	229,439	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,356,178	\$ 4,991,922	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		16,003,885	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)	\$	\$ 16,003,885	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,356,178	\$ 20,995,807	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,331,102	\$ (6,060,030)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,687,280	\$ 14,935,777	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,452,225	1
2	Restatements (describe):		2
3	Rounding	(5)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,452,220	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(48,218)	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	(72,900)	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)	\$ (121,118)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,331,102	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 16,183,007	1
2	Discounts and Allowances for all Levels	(2,211,158)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,971,849	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,836,100	6
7	Oxygen	131,279	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,967,379	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	284,912	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	43,033	19
20	Radiology and X-Ray	8,866	20
21	Other Medical Services	77,526	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 414,337	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,416	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,416	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	24,907	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 24,907	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 17,386,888	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,146,285	31
32	Health Care	6,361,110	32
33	General Administration	3,703,842	33
	B. Capital Expense		
34	Ownership	2,190,907	34
	C. Ancillary Expense		
35	Special Cost Centers	2,549,274	35
36	Provider Participation Fee	483,688	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 17,435,106	40
41	Income before Income Taxes (line 30 minus line 40)**	(48,218)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (48,218)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 5,822,190	44
45	Private Pay - Net Inpatient Revenue	135,500	45
46	Medicare - Net Inpatient Revenue	1,106,300	46
47	Other-(specify) Managed Care, Veterans, Insurance	6,491,000	47
48	Other-(specify) Veterans,Hospice	416,859	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 13,971,849	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	2,177	2,500	\$ 155,511	\$ 62.20	1
2	Assistant Director of Nursing	2,481	2,638	100,169	37.97	2
3	Registered Nurses	33,922	35,753	1,188,788	33.25	3
4	Licensed Practical Nurses	51,039	54,907	1,586,692	28.90	4
5	CNAs & Orderlies	101,335	107,627	1,246,078	11.58	5
6	CNA Trainees					6
7	Licensed Therapist	36,985	39,147	922,645	23.57	7
8	Rehab/Therapy Aides	15,666	17,122	351,685	20.54	8
9	Activity Director					9
10	Activity Assistants	8,625	9,209	114,410	12.42	10
11	Social Service Workers	11,431	12,290	196,949	16.03	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	30,112	33,740	378,848	11.23	15
16	Dishwashers					16
17	Maintenance Workers	5,375	5,668	80,085	14.13	17
18	Housekeepers	28,215	31,452	340,429	10.82	18
19	Laundry	9,827	11,207	110,791	9.89	19
20	Administrator	1,977	2,091	133,533	63.86	20
21	Assistant Administrator	2,073	2,235	67,047	30.00	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	22,954	24,890	355,474	14.28	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	8,384	9,347	291,594	31.20	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	372,578	401,823	\$ 7,620,728 *	\$ 18.97	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	\$ 66,316	01-03	35
36	Medical Director	Monthly	44,400	09-03	36
37	Medical Records Consultant	Monthly	4,800	10-03	37
38	Nurse Consultant	Monthly	76,440	10-03	38
39	Pharmacist Consultant	Monthly	4,782	10-03	39
40	Physical Therapy Consultant	87	6,104	10a-03	40
41	Occupational Therapy Consultant	39	2,872	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	72	3,780	10a-03	43
44	Activity Consultant	Monthly	2,496	11-03	44
45	Social Service Consultant	Monthly	4,898	12-03	45
46	Other(specify)				46
47					47
48	Specialized Rehab	Monthly	23,520	10a-03	48
49	TOTAL (lines 35 - 48)	198	\$ 240,408		49

C. CONTRACT NURSES

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

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

** See instructions.

XIX. SUPPORT SCHEDULES

[illegible]

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name & ID Number		Generations at Elmwood Park		STATE OF ILLINOIS	#	0040410	Report Period Beginning:	01/01/16	Ending:	12/31/16	Page 22
XX. GENERAL INFORMATION:											
(1)	Are nursing employees (RN,LPN,NA) represented by a union?			<u>Yes</u>							
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.			<u>Yes</u> <u>ICLTC:\$24970</u>							
(3)	Did the nursing home make political contributions or payments to a political action organization? If YES, have these costs been properly adjusted out of the cost report?			<u>Yes</u> <u>Yes</u>							
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? If YES, what is the capacity?			<u>No</u> <u>N/A</u>							
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?			<u>Yes</u> <u>10 Years</u>							
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$ <u>25,783</u> Line <u>10</u>							
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.			<u>Yes</u>							
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.			<u>No</u> <u>N/A</u>							
(9)	Are you presently operating under a sublease agreement?			YES <u>X</u> NO							
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u> </u> NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.			<u>N/A</u>							
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. This amount is to be recorded on line 42 of Schedule V.			\$ <u>483,688</u>							
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? If YES, attach an explanation of the allocation.			<u>No</u>							
(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?			<u>Yes</u>							
(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? 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.			<u>No</u>							
(15)	Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. Has any meal income been offset against related costs?			\$ <u>46,819</u> <u>No</u> Indicate the amount. \$ <u>N/A</u>							
(16)	Travel and Transportation										
	a. Are there costs included for out-of-state travel? If YES, attach a complete explanation.			<u>No</u>							
	b. Do you have a separate contract with the Department to provide medical transportation for residents? If YES, please indicate the amount of income earned from such a program during this reporting period.			<u>No</u> \$ <u>N/A</u>							
	c. What percent of all travel expense relates to transportation of nurses and patients?			<u>100% Ln 14</u>							
	d. Have vehicle usage logs been maintained?			<u>N/A</u>							
	e. Are all vehicles stored at the nursing home during the night and all other times when not in use?			<u>N/A</u>							
	f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?			<u>N/A</u>							
	g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period.			<u>No</u> \$ <u>N/A</u>							
(17)	Has an audit been performed by an independent certified public accounting firm? Firm Name:			<u>No</u> <u>N/A</u>							
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?			<u>Yes</u>							
(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. Attach invoices and a summary of services for all architect and appraisal fees			<u>Yes</u>							