

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0049841</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Generations at Regency</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/16</u> to <u>12/31/16</u> 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.																							
Address: <u>6631 Milwaukee Ave</u> <u>Niles</u> <u>60714</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(847) 647-7444</u> Fax # <u>(847) 647-6403</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____ *</td></tr><tr><td rowspan="4">Paid Preparer</td><td>* Subject to the attached Accountants Consulting Report (Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____ *	Paid Preparer	* Subject to the attached Accountants Consulting Report (Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>Marcum, LLP</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>												
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	(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>																								
Date of Initial License for Current Owners: <u>1/1/2008</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☒ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☐ "Sub-S" Corp.																								
	☒ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u>																									
Email Address: _____																									

Facility Name & ID Number

Generations at Regency

0049841

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	300	Skilled (SNF)	300	109,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	300	TOTALS	300	109,800	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	42,548	6,261	27,059	75,868	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,548	6,261	27,059	75,868	14

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

69.10%

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 X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES X NO

I. On what date did you start providing long term care at this location?

Date started 01/01/2008

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

YES X Date 01/01/2008 NO

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

YES X NO If YES, enter number of beds certified 300 and days of care provided 7,295

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL X MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year?

YES X 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 Regency # 0049841 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	572,822	59,203	58,627	690,652		690,652	(25,571)	665,081			1
2	Food Purchase		560,207		560,207	(37,552)	522,655	(460)	522,195			2
3	Housekeeping	365,625	80,440		446,065		446,065	(5,598)	440,467			3
4	Laundry	165,803	64,484		230,287		230,287	(695)	229,592			4
5	Heat and Other Utilities			280,597	280,597		280,597	(10,840)	269,757			5
6	Maintenance	158,591	66,613	245,458	470,662		470,662	(42,813)	427,849			6
7	Other (specify):*							7,947	7,947			7
8	TOTAL General Services	1,262,841	830,947	584,682	2,678,470	(37,552)	2,640,918	(78,029)	2,562,889			8
	B. Health Care and Programs											
9	Medical Director			77,708	77,708		77,708	1,598	79,306			9
10	Nursing and Medical Records	4,478,498	272,082	232,100	4,982,680		4,982,680	(43,757)	4,938,923			10
10a	Therapy	89,536		41,031	130,567		130,567	(13,934)	116,633			10a
11	Activities	251,884	13,484	5,944	271,312		271,312		271,312			11
12	Social Services	164,557		7,569	172,126		172,126		172,126			12
13	CNA Training											13
14	Program Transportation			685	685		685		685			14
15	Other (specify):*							11,581	11,581			15
16	TOTAL Health Care and Programs	4,984,475	285,566	365,037	5,635,078		5,635,078	(44,512)	5,590,566			16
	C. General Administration											
17	Administrative	227,268		158,400	385,668		385,668	9,670	395,338			17
18	Directors Fees											18
19	Professional Services			463,225	463,225	(3,637)	459,588	(352,089)	107,500			19
20	Dues, Fees, Subscriptions & Promotions			146,403	146,403		146,403	(62,355)	84,048			20
21	Clerical & General Office Expenses	355,356	27,616	208,782	591,754		591,754	(16,984)	574,770			21
22	Employee Benefits & Payroll Taxes			1,231,183	1,231,183	37,552	1,268,735	(44)	1,268,691			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,591	6,591		6,591	749	7,340			24
25	Other Admin. Staff Transportation			6,288	6,288		6,288	11,032	17,320			25
26	Insurance-Prop.Liab.Malpractice			295,784	295,784		295,784	30,322	326,106			26
27	Other (specify):*							50,884	50,884			27
28	TOTAL General Administration	582,624	27,616	2,516,656	3,126,896	33,915	3,160,811	(328,815)	2,831,996			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,829,940	1,144,129	3,466,375	11,440,444	(3,637)	11,436,807	(451,356)	10,985,452			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			162,541	162,541		162,541	898,584	1,061,125			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			84,584	84,584		84,584	871,738	956,322			32
33	Real Estate Taxes					3,637	3,637	904,559	908,196			33
34	Rent-Facility & Grounds			3,060,000	3,060,000		3,060,000	(3,060,000)				34
35	Rent-Equipment & Vehicles			3,484	3,484		3,484	8,150	11,634			35
36	Other (specify):*							160,463	160,463			36
37	TOTAL Ownership			3,310,609	3,310,609	3,637	3,314,246	(216,506)	3,097,740			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		611,278	1,299,891	1,911,169		1,911,169	(23,499)	1,887,670			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			581,739	581,739		581,739		581,739			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		611,278	1,881,630	2,492,908		2,492,908	(23,499)	2,469,409			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,829,940	1,755,407	8,658,614	17,243,961	(0)	17,243,961	(691,361)	16,552,600			45

THE TOTAL FOR COLUMN 5 MUST BE ZERO,PLEASE CORRECT

*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	(15,653)	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	245,785	30		9
10	Interest and Other Investment Income	(7,388)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(460)	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	(3,901)	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	(149,354)	21		24
25	Fund Raising, Advertising and Promotional	(51,347)	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	(86,319)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (68,637)		\$	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)	(622,724)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (622,724)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (691,361)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Bank Fees	\$ (6,810)	21	1
2	Theft & Damage Loss	(592)	21	2
3	PAC Dues	(9,719)	20	3
4	Non Allowable Legal	(13,287)	19	4
5	Additional R&M	3,784	06	5
6	Bldg. Co - Office Expense	(864)	21	6
7	Non-Care Depreciation	(19,230)	30	7
8	Miscellaneous Income	(1,527)	21	8
9	Jury Duty Income	(17)	10	9
10	Capitalized R&M-Bldg Co	(27,232)	06	10
11	Non-Care RE Expense	(10,825)	33	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(86,319)		49

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Generations at Regency # 0049841 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				(25,571)								(25,571)	1
2	Food Purchase	(460)											(460)	2
3	Housekeeping					(5,598)							(5,598)	3
4	Laundry					(695)							(695)	4
5	Heat and Other Utilities	(15,653)	1,792		3,021								(10,840)	5
6	Maintenance	(23,448)	5,929	(34,790)	9,794	(298)							(42,813)	6
7	Other (specify):*				7,947								7,947	7
8	TOTAL General Services	(39,561)	7,721	(34,790)	(4,809)	(6,590)							(78,029)	8
	B. Health Care and Programs													
9	Medical Director			1,598									1,598	9
10	Nursing and Medical Records	(17)		(40,950)	11,299	(12,364)	(1,725)						(43,757)	10
10a	Therapy				(13,934)								(13,934)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			6,984	4,597								11,581	15
16	TOTAL Health Care and Programs	(17)		(32,368)	1,962	(12,364)	(1,725)						(44,512)	16
	C. General Administration													
17	Administrative			(122,193)	131,863								9,670	17
18	Directors Fees													18
19	Professional Services	(13,287)		(360,858)	22,056								(352,089)	19
20	Fees, Subscriptions & Promotions	(64,967)		2,612									(62,355)	20
21	Clerical & General Office Expenses	(159,147)	864	141,214	193		(108)						(16,984)	21
22	Employee Benefits & Payroll Taxes					(44)							(44)	22
23	Inservice Training & Education													23
24	Travel and Seminar			749									749	24
25	Other Admin. Staff Transportation			11,032									11,032	25
26	Insurance-Prop.Liab.Malpractice		27,376	2,679	267								30,322	26
27	Other (specify):*			18,599	32,285								50,884	27
28	TOTAL General Administration	(237,401)	28,240	(306,166)	186,664	(44)	(108)						(328,815)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(276,979)	35,961	(373,324)	183,818	(18,998)	(1,833)						(451,356)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Generations at Regency # 0049841 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	226,555	662,524		9,505								898,584	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(7,388)	876,199	(6,214)	9,141								871,738	32
33	Real Estate Taxes	(10,825)	904,044		11,340								904,559	33
34	Rent-Facility & Grounds		(3,060,000)										(3,060,000)	34
35	Rent-Equipment & Vehicles			8,150									8,150	35
36	Other (specify):*		160,463										160,463	36
37	TOTAL Ownership	208,342	(456,770)	1,936	29,986								(216,506)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(23,499)						(23,499)	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						(23,499)						(23,499)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(68,637)	(420,809)	(371,388)	213,804	(18,998)	(25,332)						(691,361)	45

VII. RELATED PARTIES

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

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

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	\$ 3,060,000	Regency Property, LLC	100.00%	\$	\$ (3,060,000)	1
2	V	30	Depreciation - SNF		Regency Property, LLC	100.00%	662,524	662,524	2
3	V	32	Interest Income	217	Regency Property, LLC	100.00%		(217)	3
4	V	32	Interest Expense - Cambridge		Regency Property, LLC	100.00%	876,416	876,416	4
5	V	36	Mortgage Insurance		Regency Property, LLC	100.00%	160,463	160,463	5
6	V	26	Property Insurance		Regency Property, LLC	100.00%	27,376	27,376	6
7	V	33	Real Estate Taxes		Regency Property, LLC	100.00%	904,044	904,044	7
8	V	06	Repairs		Regency Property, LLC	100.00%	5,929	5,929	8
9	V	21	Office Expenses		Regency Property, LLC	100.00%	864	864	9
10	V	05	Utility		Regency Property, LLC	100.00%	1,792	1,792	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 3,060,217			\$ 2,639,408	\$ * (420,809)	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.	\$ 43,200	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	\$ 8,410	\$ (34,790)	15
16	V	9	MEDICAL DIRECTOR CONSULTS		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	1,598	1,598	16
17	V	10	NURSING	93,600	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	52,650	(40,950)	17
18	V	15	EMP. BEN.-H.C.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	6,984	6,984	18
19	V	17	ADMINISTRATIVE	158,400	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	36,207	(122,193)	19
20	V	19	PROFESSIONAL FEES	367,200	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	6,342	(360,858)	20
21	V	20	FEES,SUBSCRIPTIONS		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	2,612	2,612	21
22	V	21	CLERICAL & GENERAL	43,200	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	184,414	141,214	22
23	V	24	EDUCATION & SEMINAR		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	749	749	23
24	V	25	OTHER ADMIN. STAFF TRANS.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	11,032	11,032	24
25	V	26	INSURANCE		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	2,679	2,679	25
26	V	27	EMP. BEN.-GEN. ADMIN.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	18,599	18,599	26
27	V	32	INTEREST		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	(6,214)	(6,214)	27
28	V	35	AUTO RENTAL		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	6,889	6,889	28
29	V	35	EQUIPMENT RENTAL		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	1,261	1,261	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			\$ 705,600			\$ 334,212	\$ * (371,388)	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	\$ 36,000	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	\$ 10,429	\$ (25,571)	15
16	V	7	EMP. BEN.-DIETARY		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	1,826	1,826	16
17	V	10	NURSING SALARIES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	11,299	11,299	17
18	V	15	EMP. BEN.-NURSING		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	1,969	1,969	18
19	V	17	ADMIN./LEGAL SALARIES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	131,863	131,863	19
20	V	19	FIN. CONSULT./REGL. DIR.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	21,306	21,306	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	32,285	32,285	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	28,800	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	14,866	(13,934)	24
25	V	15	EMPLOYEE BENFITS		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	2,628	2,628	25
26	V								26
27	V	6	MAINTENANCE SALARIES	25,853	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	34,460	8,608	27
28	V	7	EMPLOYEE BENEFITS		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	6,121	6,121	28
29	V								29
30	V	5	UTILITIES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	3,021	3,021	30
31	V	6	REPAIRS AND MAINT.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	1,186	1,186	31
32	V	19	PROFESSIONAL FEES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	750	750	32
33	V	21	CLERICAL & GENERAL		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	193	193	33
34	V	26	INSURANCE		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	267	267	34
35	V	30	DEPRECIATION		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	9,505	9,505	35
36	V	32	INTEREST		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	9,141	9,141	36
37	V	33	REAL ESTATE TAXES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	11,340	11,340	37
38	V								38
39	Total			\$ 90,653			\$ 304,456	\$ * 213,804	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	3	Housekeeping	76,402	Big Ten Supply, LLC	100.00%	70,804	\$ (5,598)	15
16	V	4	Laundry	9,481	Big Ten Supply, LLC	100.00%	8,786	(695)	16
17	V	6	Repairs & Maintenance	4,068	Big Ten Supply, LLC	100.00%	3,770	(298)	17
18	V	10	Nursing And Medical Records	168,752	Big Ten Supply, LLC	100.00%	156,389	(12,364)	18
19	V	10A	Therapy		Big Ten Supply, LLC	100.00%			19
20	V	22	Employee Benefits	600	Big Ten Supply, LLC	100.00%	556	(44)	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			\$ 259,303			\$ 240,305	\$ * (18,998)	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	\$ 23,955	MAC Rx, LLC	100.00%	\$ 22,229	\$ (1,725)	15
16	V	21	Clerical & General Office Expenses	1,499	MAC Rx, LLC	100.00%	1,391	(108)	16
17	V	22	Employee Benefits		MAC Rx, LLC	100.00%			17
18	V	39	Ancillary	326,278	MAC Rx, LLC	100.00%	302,779	(23,499)	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			\$ 351,731			\$ 326,399	\$ * (25,332)	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.

YESNO

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

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

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ATIED ASSOCIATES	34.72%	ALBANY CARE INC	EVANSTON	6631 MILWAUKEE, LLC	LINCOLNWOOD	BUILDING CO.	1
2	BARRISH GROUP LTD PARTNERSHIP	12.15%	GENERATIONS AT APPLEWOOD, LLC	MATTESON	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	2
3	BRYAN BARRISH TRUST	12.15%	BRYN MAWR CARE INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	JOSHUA DAVID BEHR	1.56%	GENERATIONS AT COLUMBUS PARK, INC	CHICAGO	LONG TERM CARE LAB, LLC	LINCOLNWOOD	ANCILLARY SUPPLIES	4
5	LINDSEY ERIN BEHR	1.56%	DECATUR MANOR HEALTHCARE,LLC	DECATUR	OAKTON ARMS	DES PLAINES	ASSISTED LIVING	5
6	LORI BARRISH	1.56%	GENERATIONS AT ELMWOOD PARK, INC	ELMWOOD PARK	MAC Rx LLC	DES PLAINES	PHARMACY	6
7	MICHAEL GIANNINI TRUST	10.42%	GREENWOOD CARE, INC.	EVANSTON	GENERATIONS HEALTH NETW	LINCOLNWOOD	CONSULTING CO.	7
8	RALPH GESULADO	12.15%	GENERATIONS AT NEIGHBORS, LLC	BYRON	BIG TEN SUPPLY, LLC	LIBERTYVILLE	SUPPLY CO.	8
9	RALPH GESULADO CHILDREN'S TRUST	12.15%	GENERATIONS AT ROCK ISLAND, LLC	ROCK ISLAND				9
10	THOMAS WINTER	1.56%	WILSON CARE, INC.	CHICAGO				10
11			WESLEY REHABILITATION CENTER	AUBURN, IN				11
12			GENERATIONS AT OAKTON, LLC	DES PLAINES				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

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 Regency # **0049841** 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	Michael Giannini	Relative	Administrative	0%	See Attached	3.73	9.33%	Alloc. Salary	\$ 18,110	17-07	1
2	Tom Winter	Owner	Administrative	1.56%	See Attached	6.39	10.65%	Alloc. Salary	21,306	17-07	2
3	Bryan Barrish	Relative	Administrative	0%	See Attached	4.26	9.47%	Alloc. Salary	21,306	17-07	3
4	Sarah Barrish	Relative	Administrative	0%	See Attached	5.33	10.66%	Alloc. Salary	13,136	17-07	4
5	Kirsten Schloss	Relative	Maintenance	0%	See Attached	5.33	10.66%	Alloc. Salary	10,175	06-07	5
6	Nenita Guzman	Relative	Dietary	0%	See Attached	5.33	10.66%	Alloc. Salary	10,429	01-07	6
7	Clark Collins	Relative	Administrative	0%	See Attached	4.24	10.60%	Alloc. Salary	5,296	Var.	7
8											8
9											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	\$ 99,758		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 Regency # 0049841 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 Regency # 0049841 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	6	REPAIRS AND MAINT.	PATIENT DAYS	14	\$ 78,945	\$	75,868	\$ 8,410	1
2	9	MEDICAL DIRECTOR CONSULT	PATIENT DAYS	14	15,000		75,868	1,598	2
3	10	NURSING	PATIENT DAYS	14	494,227		75,868	52,650	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	14	65,558	494,227	75,868	6,984	4
5	17	ADMINISTRATIVE	PATIENT DAYS	14	339,874	339,874	75,868	36,207	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	14	59,533		75,868	6,342	6
7	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	14	24,522		75,868	2,612	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	14	1,731,089	1,318,665	75,868	184,414	8
9	24	EDUCATION & SEMINAR	PATIENT DAYS	14	7,033		75,868	749	9
10	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	14	103,561		75,868	11,032	10
11	26	INSURANCE	PATIENT DAYS	14	25,150		75,868	2,679	11
12	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	14	174,591		75,868	18,599	12
13	32	INTEREST	PATIENT DAYS	14	(58,326)		75,868	(6,214)	13
14	35	AUTO RENTAL	PATIENT DAYS	14	64,663		75,868	6,889	14
15	35	EQUIPMENT RENTAL	PATIENT DAYS	14	11,842		75,868	1,262	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		\$ 334,213	25

Facility Name & ID Number Generations at Regency

0049841 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1	DIETARY SALARIES	PATIENT DAYS	712,171	14	\$ 97,898	\$ 97,898	75,868	\$ 10,429	1
	2	EMP. BEN.-DIETARY	PATIENT DAYS	712,171	14	17,139		75,868	1,826	2
	3	NURSING SALARIES	PATIENT DAYS	712,171	14	106,059	106,059	75,868	11,299	3
	4	EMP. BEN.-NURSING	PATIENT DAYS	712,171	14	18,488		75,868	1,970	4
	5	ADMIN./LEGAL SALARIES	PATIENT DAYS	712,171	14	1,237,797	1,115,138	75,868	131,863	5
	6	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	712,171	14	200,000		75,868	21,306	6
	7	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	712,171	14	303,056		75,868	32,285	7
	8									8
	9									9
	10	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	322,920	13	166,688	166,688	28,800	14,866	10
	11	EMPLOYEE BENFITS	SPECIAL REHAB INC.	322,920	13	29,469		28,800	2,628	11
	12									12
	13	MAINTENANCE SALARIES	MAINTENANCE INC.	335,151	14	446,742	446,742	25,853	34,460	13
	14	EMPLOYEE BENEFITS	MAINTENANCE INC.	335,151	14	79,358		25,853	6,121	14
	15									15
	16	UTILITIES	ALLOCATED SQ FT	12,878	14	28,358		1,372	3,021	16
	17	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,878	14	11,129		1,372	1,186	17
	18	PROFESSIONAL FEES	ALLOCATED SQ FT	12,878	14	7,038		1,372	750	18
	19	CLERICAL & GENERAL	ALLOCATED SQ FT	12,878	14	1,812		1,372	193	19
	20	INSURANCE	ALLOCATED SQ FT	12,878	14	2,507		1,372	267	20
	21	DEPRECIATION	ALLOCATED SQ FT	12,878	14	89,214		1,372	9,505	21
	22	INTEREST	ALLOCATED SQ FT	12,878	14	85,804		1,372	9,141	22
	23	REAL ESTATE TAXES	ALLOCATED SQ FT	12,878	14	106,445		1,372	11,340	23
	24									24
	25	TOTALS				\$ 3,035,001	\$ 1,932,526		\$ 304,456	25

Facility Name & ID Number Generations at Regency # 0049841 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	3	Housekeeping	Direct Allocation					70,804	1
	2	4	Laundry	Direct Allocation					8,786	2
	3	6	Repairs & Maintenance	Direct Allocation					3,770	3
	4	10	Nursing And Medical Records	Direct Allocation					156,389	4
	5	10A	Therapy	Direct Allocation						5
	6	22	Employee Benefits	Direct Allocation					556	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				\$	\$		240,305	25

Facility Name & ID Number Generations at Regency # 0049841 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing And Medical Records	Direct Allocation			\$	\$		22,229	1
2	21	Clerical & General Office Expense	Direct Allocation						1,391	2
3	22	Employee Benefits	Direct Allocation							3
4	39	Ancillary	Direct Allocation						302,779	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					\$	\$		326,399	25

Facility Name & ID Number Generations at Regency # 0049841 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 Regency # 0049841 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 Regency # 0049841 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 Regency # 0049841 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 Regency # 0049841 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	Mortgage Payable		X				\$	24,812,576			\$	876,416	1
2													2
3													3
4													4
5					-								5
	Working Capital												
6	Lake Forest Bank		X	Line of Credit				2,040,000				84,584	6
7	1st Source Bank		X	Vehicle Note				35,065					7
8	Allocated from SIR Management				-							9,141	8
9	TOTAL Facility Related						\$	26,887,641			\$	970,140	9
	B. Non-Facility Related*												
10	Interest Income		X									(7,388)	10
11	Interest Income - Bldg. Co		X									(217)	11
12	Allocated from SIR Management											(6,214)	12
13					-								13
14	TOTAL Non-Facility Related						\$				\$	(13,819)	14
15	TOTALS (line 9+line14)						\$	26,887,641			\$	956,322	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 160,463 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							\$					\$	8
9													9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital												14
	B. Non-Facility Related*												
15							\$					\$	15
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related												20

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

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.)

B. Real Estate Taxes

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Generations at Regency COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049841

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</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>10-31-401-046-0000</u>	<u>Long Term Care Property</u>	\$ <u>890,957.88</u>	\$ <u>880,132.74</u>
2. <u>See Attached</u>	<u>Home Office</u>	\$ <u>123,678.12</u>	\$ <u>10,319.22</u>
3. <u>See Attached</u>	<u>SIR Training</u>	\$ <u>890,957.88</u>	\$ <u>1,153.29</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>1,905,593.88</u></u>	\$ <u><u>891,605.25</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 providecopies 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 NAMEGenerations at RegencyCOUNTYCook

FACILITY IDPH LICENSE NUMBER0049841

CONTACT PERSON REGARDING THIS REPORTSteve Lavenda

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

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

A. Square Feet: 89,951

B. General Construction Type: Exterior Brick Frame Steel Number of Stories 5

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).
SIR/Generations HN Training Center - Separate Building

E. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2009	\$ 875,000	1
2					2
3	TOTALS			\$ 875,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	300			1976	\$ 12,900,000	\$ 643,294	39	\$ 330,769	\$ (312,525)	\$ 2,267,031
5										
6										
7										
8										
	Improvement Type**									
9	Various		2008	252,676		20	11,834	11,834		121,558
10	Various		2009	547,020		20	47,848	47,848		168,993
11	Various		2010	392,518		20	20,023	20,023		131,710
12	Various		2011	827,017		20	41,335	41,335		250,706
13	Various		2012	124,944		20	6,457	6,457		28,455
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Generations at Regency

0049841

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		8,304,620			415,231	415,231	2,529,685	67
68	Related Party Allocations (Pages 12H & 12I)		220,687	5,680		8,225	2,545	114,744	68
69	Financial Statement Depreciation			162,541			(162,541)		69
70	TOTAL (lines 4 thru 69)		\$ 23,569,482	\$ 811,515		\$ 881,723	\$ 70,208	\$ 5,612,882	70

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

Facility Name & ID Number Generations at Regency

0049841

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		\$ 23,569,482	\$ 811,515		\$ 881,723	\$ 70,208	\$ 5,612,882	1
2	Crash Rails - 3Rd And 4Th Floor Dining Rooms	2013	4,628		20	231	231	906	2
3	Water Main Upgrade	2013	14,950		20	748	748	2,741	3
4	Air Conditioner	2013	5,158		20	258	258	924	4
5	Furnish & Install New Tank Unit In Elevator	2013	9,870		20	494	494	1,686	5
6	Install Windows Throughout Entire Building	2013	224,726		20	11,236	11,236	41,200	6
7	Repipe Water Line	2013	3,200		20	160	160	627	7
8	Spray Fireproofing	2013	6,380		20	319	319	1,196	8
9	Wall Unit Air Conditioners	2013	7,993		20	400	400	1,465	9
10	Sprinkler System Work	2014	7,681		20	384	384	1,120	10
11	Air Conditioner Cut Outs	2014	3,600		20	180	180	525	11
12	Custom Cabinets - 3 Rms And Patient	2014	16,200		20	810	810	2,430	12
13	Fire Sprinkler Line Valve	2014	9,350		20	468	468	1,247	13
14	Front Door Access Control	2014	4,859		20	243	243	506	14
15	Masonry Infills	2014	3,460		20	173	173	476	15
16	10 Air Conditioners	2014	6,199		20	310	310	827	16
17	Video Camera & Monitors	2015	2,792		20	140	140	151	17
18	Freight Elevator - Replace Defective Board	2015	2,971		20	149	149	210	18
19	Hvac Coiled Replacement	2016	16,785		20	140	140	140	19
20	Elevator-Pump Unit	2016	13,790		20	57	57	57	20
21	Install/Compact Two Traffic Control Bumps	2016	3,150		20	26	26	26	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)		\$ 23,937,224	\$ 811,515		\$ 898,647	\$ 87,132	\$ 5,671,343	34

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

Facility Name & ID Number Generations at Regency

0049841

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 23,937,224	\$ 811,515		\$ 898,647	\$ 87,132	\$ 5,671,343	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
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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)		\$ 23,937,224	\$ 811,515		\$ 898,647	\$ 87,132	\$ 5,671,343	34

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

Facility Name & ID Number Generations at Regency

0049841

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 23,937,224	\$ 811,515		\$ 898,647	\$ 87,132	\$ 5,671,343	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		\$ 23,937,224	\$ 811,515		\$ 898,647	\$ 87,132	\$ 5,671,343	34

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

Facility Name & ID Number Generations at Regency

0049841

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 23,937,224	\$ 811,515		\$ 898,647	\$ 87,132	\$ 5,671,343	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)		\$ 23,937,224	\$ 811,515		\$ 898,647	\$ 87,132	\$ 5,671,343	34

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

Facility Name & ID Number Generations at Regency

0049841

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	Wallpaper/Installation	2009	18,410		20	921	921	7,365	9
10	Flooring	2009	44,832		20	2,242	2,242	17,933	10
11	Hand Rails/ Guards	2009	29,804		20	1,490	1,490	11,921	11
12	Drapes, Cubicles, Coverlets	2010	166,306		20	8,315	8,315	58,207	12
13	Handrails	2010	59,608		20	2,980	2,980	20,862	13
14	Dialysis Room Piping	2010	19,324		20	966	966	6,763	14
15	Painting- 2nd Floor	2010	35,410		20	1,771	1,771	12,394	15
16	Painting- 4th Floor	2009	52,610		20	2,631	2,631	21,045	16
17	Pegasus- Nursing Stations	2009	165,000		20	8,250	8,250	66,000	17
18	Built In Furniture	2009	299,000		20	14,950	14,950	119,600	18
19	Flooring	2009	208,860		20	10,443	10,443	83,544	19
20	Flooring	2010	116,064		20	5,803	5,803	40,622	20
21	Window Treatments	2010	7,202		20	360	360	2,521	21
22	Corner Gaurds	2010	5,103		20	255	255	1,786	22
23	Flooring	2010	15,532		20	777	777	5,437	23
24	Telephone System	2010	42,428		20	2,121	2,121	14,849	24
25	Overbed Lights	2010	5,573		20	279	279	1,951	25
26	Overbed Lights	2010	9,240		20	462	462	3,234	26
27	Interior Signage	2010	5,424		20	271	271	1,898	27
28	Interior Signage	2010	4,305		20	215	215	1,507	28
29	Lighting	2010	26,692		20	1,335	1,335	9,343	29
30	1st Floor Resident Room Work	2011	4,500		20	225	225	1,350	30
31	PT Recovery Room	2011	4,000		20	200	200	1,200	31
32	Dialysis Water Purification	2011	6,385		20	319	319	1,915	32
33	Custom Cabinets	2011	4,000		20	200	200	1,200	33
34	TOTAL (lines 1 thru 33)		\$ 1,355,612	\$		\$ 67,781	\$ 67,781	\$ 514,446	34

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

Facility Name & ID Number Generations at Regency

0049841

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 12F, Carried Forward		\$ 1,355,612	\$		\$ 67,781	\$ 67,781	\$ 514,446	1
2	Grocery Cabinets	2011	7,900		20	395	395	2,370	2
3	Outdoor Iron Gates and Fencing	2011	9,245		20	462	462	2,773	3
4	Sump Pump	2011	7,342		20	367	367	2,203	4
5	Landscape Improvements - Trees & Plants	2011	11,340		20	567	567	3,402	5
6	1st Floor Suites - Cabinets & Granite Tops	2011	28,700		20	1,435	1,435	8,610	6
7	Cabinetry	2011	8,600		20	430	430	2,580	7
8	Window Treatment	2011	11,587		20	579	579	3,476	8
9	Window Treatment	2011	19,302		20	965	965	5,791	9
10	Window Treatments	2011	3,003		20	150	150	901	10
11	Cubicle Curtains - Dialysis	2011	7,051		20	353	353	2,116	11
12	Install Corner Guards	2011	3,840		20	192	192	1,152	12
13	Kitchen Dishwasher Install	2011	5,306		20	265	265	1,592	13
14	Family Room Wall Prep & Paint	2011	2,700		20	135	135	810	14
15	Mason Wall for Garbage Enclosure	2011	6,500		20	325	325	1,950	15
16	Dialysis, Therapy, & Dining Rooms & 1st Flr & Basement Remodel	2011	5,662,788		20	283,139	283,139	1,698,836	16
17	Architect Fees-Dialysis, Therapy&Dining Rooms&1st Flr&Basement	2011	479,093		20	23,955	23,955	143,728	17
18	Fees Dialysis, Therapy & Dining Rooms & 1st Flr & Basement Remo	2011	299,630		20	14,982	14,982	89,890	18
19	Contractor Fee - Dialysis, Therapy & Dining Rooms & 1st Flr & Base	2011	36,491		20	1,825	1,825	10,948	19
20	Administrative Offices	2009	250,000		20	12,500	12,500	25,000	20
21	Walk-in Freezer Work	2015	8,484		20	424	424	848	21
22	Door to Walk-in Freezer	2015	4,767		20	238	238	476	22
23	Wireless Network Upgrade	2015	15,589		20	779	779	1,558	23
24	Custom Elevator Pit Ladder	2015	10,665		20	533	533	1,066	24
25	Parking Lot Re-Stripe	2015	7,400		20	370	370	740	25
26	Stairwell Safety Signs	2015	2,591		20	130	130	260	26
27	Thru Wall Air Conditioners	2015	4,207		20	210	210	420	27
28	LED Lighting	2016	24,258		20	1,213	1,213	1,213	28
29	Outdoor Sign	2016	7,655		20	383	383	383	29
30	Privacy Curtains 3rd and 4th floors	2016	2,974		20	149	149	149	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,304,620	\$		\$ 415,231	\$ 415,231	\$ 2,529,685	34

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

Facility Name & ID Number Generations at Regency

0049841

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	<u>Allocated - S.I.R. Management & Generations HC Network</u>	2009	53,269	1,366	39	1,366		9,618	3
4	<u>Allocated - S.I.R. Properties - S.I.R. Management</u>	1993	48,226	1,531	35	1,378	(153)	32,380	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	<u>Allocated - S.I.R. Management & Generations HC Network</u>	1993	12,227	340	20		(340)	12,227	9
10	<u>Allocated - S.I.R. Management & Generations HC Network</u>	1994	38		20			38	10
11	<u>Allocated - S.I.R. Management & Generations HC Network</u>	1995	279		20			279	11
12	<u>Allocated - S.I.R. Management & Generations HC Network</u>	1997	18,787		20	916	916	18,472	12
13	<u>Allocated - S.I.R. Management & Generations HC Network</u>	1999	1,477		20	74	74	1,273	13
14	<u>Allocated - S.I.R. Management & Generations HC Network</u>	2000	1,744		20	87	87	1,443	14
15	<u>Allocated - S.I.R. Management & Generations HC Network</u>	2007	5,604		20	280	280	2,576	15
16	<u>Allocated - S.I.R. Management & Generations HC Network</u>	2008	15,444	1,544	20	973	(571)	8,610	16
17	<u>Allocated - S.I.R. Management & Generations HC Network</u>	2009	38,376	351	20	1,919	1,568	13,901	17
18	<u>Allocated - S.I.R. Management & Generations HC Network</u>	2011	949	95	20	95		514	18
19	<u>Allocated - S.I.R. Management & Generations HC Network</u>	2012	3,038	152	20	152		671	19
20	<u>Allocated - S.I.R. Management & Generations HC Network</u>	2014	426	43	20	21	(22)	55	20
21	<u>Allocated - S.I.R. Management & Generations HC Network</u>	2016	554	12	20	12		12	21
22									22
23	<u>Allocated - S.I.R. Properties - S.I.R. Management/Generations</u>	2012	2,954	148	20	148		592	23
24	<u>Allocated - S.I.R. Properties - S.I.R. Management/Generations</u>	2010	2,910		20	146	146	922	24
25	<u>Allocated - S.I.R. Properties - S.I.R. Management/Generations</u>	2009	2,896	65	20	145	80	1,129	25
26	<u>Allocated - S.I.R. Properties - S.I.R. Management/Generations</u>	2007	844	17	20	42	25	422	26
27	<u>Allocated - S.I.R. Properties - S.I.R. Management/Generations</u>	2002	191		20	10	10	139	27
28	<u>Allocated - S.I.R. Properties - S.I.R. Management/Generations</u>	1999	6,111		20	306	306	5,347	28
29	<u>Allocated - S.I.R. Properties - S.I.R. Management/Generations</u>	1998	2,920		20	146	146	2,701	29
30	<u>Allocated - S.I.R. Properties - S.I.R. Management/Generations</u>	1997	182		20	9	9	182	30
31	<u>Allocated - S.I.R. Properties - S.I.R. Management/Generations</u>	1994	459	12	20		(12)	459	31
32	<u>Allocated - S.I.R. Properties - S.I.R. Management/Generations</u>	1993	782	4	20		(4)	782	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 220,687	\$ 5,680		\$ 8,225	\$ 2,545	\$ 114,744	34

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

Facility Name & ID Number Generations at Regency

0049841

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 220,687	\$ 5,680		\$ 8,225	\$ 2,545	\$ 114,744	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		\$ 220,687	\$ 5,680		\$ 8,225	\$ 2,545	\$ 114,744	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	\$1,579,761	\$3,463	\$158,567	\$155,104	10	\$998,310	71
72	Current Year Purchases	1,001	36	36		10	36	72
73	Fully Depreciated Assets	104,746		34	34	10	104,746	73
74								74
75	TOTALS	\$1,685,508	\$3,499	\$158,637	\$155,138		\$1,103,092	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		2016 T150 Transit Van	2016	\$46,901	\$	\$3,518	\$3,518	5	\$3,518	76
77		Allocated from SIR Management	2016	3,745	327	324	(3)	5	2,882	77
78										78
79										79
80	TOTALS			\$50,646	\$327	\$3,842	\$3,515		\$6,400	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)	\$26,548,378	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$815,341	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$1,061,126	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$245,785	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$6,780,834	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	Office Building - 2009	\$750,000	\$19,230	\$135,417	86
87	Land- Vacant Parcel - 2009	400,000			87
88	Land- Office Buidling - 2009	225,000			88
89					89
90					90
91	TOTALS	\$1,375,000	\$19,230	\$135,417	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

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

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?
16. Rental Amount for movable equipment: \$ 4,745
- Description: See Attached Schedule
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from SIR/Generations HN		\$	\$ 6,889	17
18					18
19					19
20					20
21	TOTAL		\$ -	\$ 6,889	21

10. Effective dates of current rental agreement:

Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2017	\$
13.	/2018	\$
14.	/2019	\$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

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

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 497,889	\$		\$ 497,889	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			125,712			125,712	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			580,752			580,752	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				326,735		326,735	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					95,538	284,543		380,081	13
14	TOTAL			\$		\$ 1,299,891	\$ 611,278		\$ 1,911,169	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 6,576	\$ 118,623	1
2	Cash-Patient Deposits	83,437	83,437	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,406,752	2,406,752	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	54,000	176,704	6
7	Other Prepaid Expenses	2,412	2,412	7
8	Accounts Receivable (owners or related parties)	200,000	200,000	8
9	Other(specify):		761,742	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,753,177	\$ 3,749,670	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,500,000	13
14	Buildings, at Historical Cost		19,842,535	14
15	Leasehold Improvements, at Historical Cost	2,267,988	3,874,607	15
16	Equipment, at Historical Cost	626,691	1,722,953	16
17	Accumulated Depreciation (book methods)	(985,637)	(5,462,052)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	88,353	8,453,751	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,997,395	\$ 29,931,794	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,750,572	\$ 33,681,464	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 701,260	\$ 701,260	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	83,437	83,437	28
29	Short-Term Notes Payable	2,075,065	2,075,065	29
30	Accrued Salaries Payable	315,311	315,311	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,122	13,122	31
32	Accrued Real Estate Taxes(Sch.IX-B)		935,500	32
33	Accrued Interest Payable		73,404	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	144,284	144,284	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,332,479	\$ 4,341,383	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		24,812,576	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)	\$	\$ 24,812,576	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,332,479	\$ 29,153,959	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,418,093	\$ 4,527,505	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,750,572	\$ 33,681,464	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,504,631	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)	\$ 1,504,636	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	201,457	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	(288,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (86,543)	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)	\$ 1,418,093	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Generations at Regency

0049841

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 16,345,603	1
2	Discounts and Allowances for all Levels	(3,650,075)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,695,528	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,345,326	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,345,326	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	303,218	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	30,550	19
20	Radiology and X-Ray	15,612	20
21	Other Medical Services	46,252	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 395,632	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,388	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,388	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,544	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,544	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 17,445,418	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,678,470	31
32	Health Care	5,635,078	32
33	General Administration	3,126,896	33
	B. Capital Expense		
34	Ownership	3,310,609	34
	C. Ancillary Expense		
35	Special Cost Centers	1,911,169	35
36	Provider Participation Fee	581,739	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 17,243,961	40
41	Income before Income Taxes (line 30 minus line 40)**	201,457	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 201,457	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 7,393,863	44
45	Private Pay - Net Inpatient Revenue	1,344,042	45
46	Medicare - Net Inpatient Revenue	636,745	46
47	Other-(specify) <u>Managed Care/Insurance</u>	2,758,807	47
48	Other-(specify) <u>Hospice</u>	562,071	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 12,695,528	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Note 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	2,043	2,091	\$ 110,711	\$ 52.95	1
2	Assistant Director of Nursing	1,874	1,930	76,030	39.39	2
3	Registered Nurses	43,149	45,723	1,388,554	30.37	3
4	Licensed Practical Nurses	39,164	41,639	1,080,739	25.95	4
5	CNAs & Orderlies	116,810	126,995	1,559,517	12.28	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,852	5,365	89,536	16.69	8
9	Activity Director					9
10	Activity Assistants	21,438	22,995	251,884	10.95	10
11	Social Service Workers	9,426	10,195	164,557	16.14	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	45,649	49,438	572,822	11.59	15
16	Dishwashers					16
17	Maintenance Workers	6,857	7,758	158,591	20.44	17
18	Housekeepers	33,541	36,453	365,625	10.03	18
19	Laundry	15,795	17,245	165,803	9.61	19
20	Administrator	1,970	2,091	129,136	61.76	20
21	Assistant Administrator	3,017	3,227	98,132	30.41	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	19,994	21,324	355,356	16.66	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	7,245	7,848	202,271	25.77	31
32	Other Health Care(specify)					32
33	Other(specify)	1,874	2,091	60,676	29.02	33
34	TOTAL (lines 1 - 33)	374,698	404,408	\$ 6,829,940 *	\$ 16.89	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 58,627	01-03	35
36	Medical Director	Monthly	77,708	09-03	36
37	Medical Records Consultant	Monthly	4,800	10-03	37
38	Nurse Consultant	Monthly	93,600	10-03	38
39	Pharmacist Consultant	Monthly	4,482	10-03	39
40	Physical Therapy Consultant	109	5,456	10a-03	40
41	Occupational Therapy Consultant	109	5,404	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	28	1,371	10a-03	43
44	Activity Consultant	Monthly	5,944	11-03	44
45	Social Service Consultant	Monthly	5,169	12-03	45
46	Other(specify)				46
47	Med. Director - Psychiatric	Monthly	2,400	12-03	47
48	Dir. Of Specialized Services	Monthly	28,800	10a-03	48
49	TOTAL (lines 35 - 48)	246	\$ 293,761		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	15	\$ 462	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	5,188	128,756	10-03	52
53	TOTAL (lines 50 - 52)	5,203	\$ 129,218		53

STATE OF ILLINOIS

Page 21

Facility Name & ID Number

Generations at Regency

0049841

Report Period Beginning:

01/01/16

Ending:

12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lorrie Butler	Administrator	0	\$ 129,136
Lea Radunsky	Asst. Admin	0	98,132
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 227,268

B. Administrative - Other

Description	Amount
SIR/Generations HN - Director of Administrative Services	\$ 86,400
SIR/Generations HN - Ancillary Administrative Charges	72,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 158,400

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	\$ 18,345
Plante Moran	Accounting	4,125
PayChex	Payroll Services	18,678
Legat Architect	Architecture	1,042
Achieve Accreditation	Accreditation	17,226
E-Health Data	Data Processing	3,600
Pinnacle	Customer Satisfaction	3,868
H.K. Payroll	WOTC Consulting	2,950
OnShift	Management Software	2,935
Property Valuation Services	Property Valuation	3,000
Personnel Planners	Unemployment Tax Consultant	2,205
See Supplemental Schedule		385,252
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 463,225

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 137,541
Unemployment Compensation Insurance	76,610
FICA Taxes	513,574
Employee Health Insurance	474,853
Employee Meals	37,552
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	21,936
401K Matching Contributions	6,670
Allocated from Big Ten Supply, LLC	(45)
TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,268,691

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	29,457
Health Care Worker Background Check (Indicate # of checks performed 520)	5,205
Patient Background Checks	
Dues & Subscriptions	25,090
Licenses & Permits	21,684
Allocated from SIR Management	2,612
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 84,048

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	6,591
Allocated from SIR Management	749
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 7,340

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number Generations at Regency 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? <u>Yes</u> If YES, give association name and amount. <u>ICLTC: \$29,453</u> (3) Did the nursing home make political contributions or payments to a political action organization? <u>Yes</u> If YES, have these costs been properly adjusted out of the cost report? <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? <u>No</u> If YES, what is the capacity? <u>N/A</u> (5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u> What was the average life used for new equipment added during this period? <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>47,060</u> Line <u>10</u> (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation. (8) Are you presently operating under a sale and leaseback arrangement? <u>No</u> If YES, give effective date of lease. <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 _____ 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. \$ <u>581,739</u> This amount is to be recorded on line 42 of Schedule V. (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>No</u> If YES, attach an explanation of the allocation.	Page 22 STATE OF ILLINOIS # <u>0049841</u> Report Period Beginning: <u>01/01/16</u> Ending: <u>12/31/16</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? <u>No</u> For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions. (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ <u>37,552</u> Has any meal income been offset against related costs? <u>No</u> Indicate the amount. \$ <u>N/A</u> (16) Travel and Transportation a. Are there costs included for out-of-state travel? <u>No</u> If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <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>Yes</u> e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>No</u> f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>Yes</u> g. Does the facility transport residents to and from day training? <u>No</u> Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>N/A</u> (17) Has an audit been performed by an independent certified public accounting firm? <u>No</u> Firm Name: <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. <u>Yes</u> Attach invoices and a summary of services for all architect and appraisal fees
--	---