

Facility Name & ID Number Generations At Regency Llc

0049841 Report Period Beginning: 01/01/18 Ending: 12/31/18

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	300	Skilled (SNF)	300	109,500	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	109,500	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	14,639	6,436	47,964	69,039	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,639	6,436	47,964	69,039	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.05%

D. How many bed reserve days during this year were paid by the Department?

None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

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

YES NO

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

Date started 01/01/2008

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

YES Date 01/01/2008 NO

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

YES NO If YES, enter number of beds certified 300 and days of care provided 7,398

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Generations At Regency Llc # 0049841 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	573,049	63,797	59,725	696,571		696,571	(16,909)	679,662		1
2	Food Purchase		500,781		500,781	(36,628)	464,153	(464)	463,689		2
3	Housekeeping	391,566	63,180		454,746		454,746	(3,946)	450,800		3
4	Laundry	33,667	24,776	229,634	288,077		288,077	(488)	287,589		4
5	Heat and Other Utilities			259,529	259,529		259,529	(10,852)	248,677		5
6	Maintenance	170,724	52,095	223,734	446,553		446,553	66	446,619		6
7	Other (specify):*							5,183	5,183		7
8	TOTAL General Services	1,169,006	704,629	772,622	2,646,257	(36,628)	2,609,629	(27,410)	2,582,219		8
	B. Health Care and Programs										
9	Medical Director			90,000	90,000		90,000		90,000		9
10	Nursing and Medical Records	4,788,555	297,897	867,183	5,953,635		5,953,635	(58,507)	5,895,128		10
10a	Therapy	203,512		31,292	234,804		234,804	(4,876)	229,928		10a
11	Activities	248,712	16,695	6,662	272,069		272,069		272,069		11
12	Social Services	295,877		6,700	302,577		302,577		302,577		12
13	CNA Training										13
14	Program Transportation			4,109	4,109		4,109		4,109		14
15	Other (specify):*							10,292	10,292		15
16	TOTAL Health Care and Programs	5,536,656	314,592	1,005,946	6,857,194		6,857,194	(53,091)	6,804,103		16
	C. General Administration										
17	Administrative	193,227		190,800	384,027		384,027	(11,909)	372,118		17
18	Directors Fees										18
19	Professional Services			672,674	672,674	(447)	672,227	(509,000)	163,227		19
20	Dues, Fees, Subscriptions & Promotions			85,823	85,823		85,823	(52,100)	33,723		20
21	Clerical & General Office Expenses	164,998	27,197	242,631	434,826		434,826	(26,193)	408,633		21
22	Employee Benefits & Payroll Taxes			1,203,616	1,203,616	36,628	1,240,244	(319)	1,239,925		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,924	2,924		2,924	207	3,131		24
25	Other Admin. Staff Transportation			4,913	4,913		4,913	21,289	26,202		25
26	Insurance-Prop.Liab.Malpractice			370,224	370,224		370,224	24,909	395,133		26
27	Other (specify):*							45,887	45,887		27
28	TOTAL General Administration	358,225	27,197	2,773,605	3,159,027	36,180	3,195,207	(507,229)	2,687,978		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,063,887	1,046,418	4,552,173	12,662,478	(447)	12,662,031	(587,730)	12,074,301		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			150,090	150,090		150,090	912,870	1,062,960			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			158,528	158,528		158,528	751,179	909,707			32
33	Real Estate Taxes					447	447	950,469	950,916			33
34	Rent-Facility & Grounds			2,949,000	2,949,000		2,949,000	(2,949,000)				34
35	Rent-Equipment & Vehicles			3,714	3,714		3,714	5,050	8,764			35
36	Other (specify):*							154,555	154,555			36
37	TOTAL Ownership			3,261,332	3,261,332	447	3,261,779	(174,877)	3,086,902			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		390,891	1,505,658	1,896,549		1,896,549	(28,346)	1,868,203			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			534,582	534,582		534,582		534,582			42
43	Other (specify):*			125	125		125	(125)				43
44	TOTAL Special Cost Centers		390,891	2,040,365	2,431,256		2,431,256	(28,471)	2,402,785			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,063,887	1,437,309	9,853,870	18,355,066	(0)	18,355,066	(791,078)	17,563,988			45

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

Generations At Regency Llc

ID# 0049841

Report Period Beginning: 01/01/18

Ending: 12/31/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Office Expense - Bank Fees	\$ (7,529)	21	1
2	Office Exp - Credit Card Fees	(24)	21	2
3	Theft & Damage Loss	(2,627)	21	3
4	PAC Dues	(12,807)	20	4
5	Non-allowable Interest	(55,460)	32	5
6	Non-allowable Seminars	(129)	24	6
7	Capitalized R&M	(7,062)	06	7
8	Collections Expense	(9,186)	19	8
9	Non-allowable Legal	(8,697)	19	9
10	Marketing Expense	(125)	43	10
11	Miscellaneous Income	(1,500)	21	11
12	Jury Duty	(34)	10	12
13	Chamber of Commerce	(940)	20	13
14	Red Light Ticket	(100)	25	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	(106,220)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Generations At Regency Llc# 0049841

Report Period Beginning:

01/01/18

Ending:

12/31/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(16,909)								(16,909)	1
2	Food Purchase	(464)											(464)	2
3	Housekeeping						(3,946)						(3,946)	3
4	Laundry						(488)						(488)	4
5	Heat and Other Utilities	(17,491)	4,133		2,506								(10,852)	5
6	Maintenance	(7,062)	12,376	(8,756)	3,937		(429)						66	6
7	Other (specify):*			1,465	3,718								5,183	7
8	TOTAL General Services	(25,017)	16,509	(7,291)	(6,747)		(4,863)						(27,410)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(34)		(51,078)	9,414	(4,090)	(12,719)						(58,507)	10
10a	Therapy				(4,763)		(113)						(4,876)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			7,110	3,182								10,292	15
16	TOTAL Health Care and Programs	(34)		(43,968)	7,833	(4,090)	(12,832)						(53,091)	16
	C. General Administration													
17	Administrative			(157,669)	145,760								(11,909)	17
18	Directors Fees													18
19	Professional Services	(17,883)		(508,790)	17,673								(509,000)	19
20	Fees, Subscriptions & Promotions	(52,235)		135									(52,100)	20
21	Clerical & General Office Expenses	(147,722)		121,520	133	(124)							(26,193)	21
22	Employee Benefits & Payroll Taxes					(319)							(319)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(129)		336									207	24
25	Other Admin. Staff Transportation	(100)		21,389									21,289	25
26	Insurance-Prop.Liab.Malpractice		22,733	1,866	310								24,909	26
27	Other (specify):*			11,771	34,116								45,887	27
28	TOTAL General Administration	(218,069)	22,733	(509,442)	197,992	(443)							(507,229)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(243,120)	39,241	(560,701)	199,078	(4,533)	(17,695)						(587,730)	29

STATE OF ILLINOIS

Facility Name & ID Number Generations At Regency Llc# 0049841

Report Period Beginning:

01/01/18

Ending:

Summary B

12/31/18

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	205,687	700,449		6,734								912,870	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(63,859)	843,874	(34,940)	6,104								751,179	32
33	Real Estate Taxes		940,768		9,701								950,469	33
34	Rent-Facility & Grounds		(2,949,000)										(2,949,000)	34
35	Rent-Equipment & Vehicles			5,050									5,050	35
36	Other (specify):*		154,555										154,555	36
37	TOTAL Ownership	141,828	(309,354)	(29,890)	22,539								(174,877)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(28,346)							(28,346)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(125)											(125)	43
44	TOTAL Special Cost Centers	(125)				(28,346)							(28,471)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(101,418)	(270,113)	(590,591)	221,617	(32,879)	(17,695)						(791,078)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rental Income	\$ 2,949,000	Regency Property, LLC		\$	\$ (2,949,000)	1
2	V	30 Depreciation		Regency Property, LLC		700,449	700,449	2
3	V	32 Interest	261	Regency Property, LLC		844,135	843,874	3
4	V	36 MIP Expense		Regency Property, LLC		154,555	154,555	4
5	V	26 Property Insurance		Regency Property, LLC		22,733	22,733	5
6	V	33 Real Estate Taxes		Regency Property, LLC		940,768	940,768	6
7	V	06 Repairs and Maintenance		Regency Property, LLC		6,549	6,549	7
8	V	06 Other Maintenance Expense		Regency Property, LLC		5,827	5,827	8
9	V	05 Utilities		Regency Property, LLC		4,133	4,133	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 2,949,261			\$ 2,679,148	\$ * (270,113)	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.	\$ 25,200	GENERATIONS HC NETWORK, LLC		\$ 16,444	\$ (8,756)	15
16	V	7 EMP. BEN.-GEN. SERV.		GENERATIONS HC NETWORK, LLC		1,465	1,465	16
17	V	9 MEDICAL DIRECTOR CONSULTS		GENERATIONS HC NETWORK, LLC				17
18	V	10 NURSING	93,600	GENERATIONS HC NETWORK, LLC		42,522	(51,078)	18
19	V	15 EMP. BEN.-H.C.		GENERATIONS HC NETWORK, LLC		7,110	7,110	19
20	V	17 ADMINISTRATIVE	190,800	GENERATIONS HC NETWORK, LLC		33,131	(157,669)	20
21	V	19 PROFESSIONAL FEES	522,000	GENERATIONS HC NETWORK, LLC		13,210	(508,790)	21
22	V	20 FEES,SUBSCRIPTIONS		GENERATIONS HC NETWORK, LLC		135	135	22
23	V	21 CLERICAL & GENERAL	64,800	GENERATIONS HC NETWORK, LLC		186,320	121,520	23
24	V	24 EDUCATION & SEMINAR		GENERATIONS HC NETWORK, LLC		336	336	24
25	V	25 OTHER ADMIN. STAFF TRANS.		GENERATIONS HC NETWORK, LLC		21,389	21,389	25
26	V	26 INSURANCE		GENERATIONS HC NETWORK, LLC		1,866	1,866	26
27	V	27 EMP. BEN.-GEN. ADMIN.		GENERATIONS HC NETWORK, LLC		11,771	11,771	27
28	V	32 INTEREST		GENERATIONS HC NETWORK, LLC		(34,940)	(34,940)	28
29	V	35 AUTO RENTAL		GENERATIONS HC NETWORK, LLC		4,073	4,073	29
30	V	35 EQUIPMENT RENTAL		GENERATIONS HC NETWORK, LLC		977	977	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		\$ 896,400			\$ 305,809	\$ * (590,591)	39

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

Facility Name & ID Number

Generations At Regency Llc

0049841

Report Period Beginning:

01/01/18

Ending:

12/31/18

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1	DIETARY SALARIES	\$ 25,200	GENERATIONS HC NETWORK, LLC	\$ 8,291	\$ (16,909)
16	V	7	EMP. BEN.-DIETARY		GENERATIONS HC NETWORK, LLC	1,388	1,388
17	V	10	NURSING SALARIES		GENERATIONS HC NETWORK, LLC	9,414	9,414
18	V	15	EMP. BEN.-NURSING		GENERATIONS HC NETWORK, LLC	1,566	1,566
19	V	17	ADMIN./LEGAL SALARIES		GENERATIONS HC NETWORK, LLC	145,760	145,760
20	V	19	FIN. CONSULT./REGL. DIR.		GENERATIONS HC NETWORK, LLC	17,299	17,299
21	V	27	EMP. BEN.-ADMINISTRATIVE		GENERATIONS HC NETWORK, LLC	34,116	34,116
22	V						
23	V						
24	V	10A	DIRECTOR OF SPECIAL REHAB	14,400	GENERATIONS HC NETWORK, LLC	9,637	(4,763)
25	V	15	EMPLOYEE BENEFITS		GENERATIONS HC NETWORK, LLC	1,616	1,616
26	V						
27	V	6	MAINTENANCE SALARIES	10,710	GENERATIONS HC NETWORK, LLC	13,198	2,488
28	V	7	EMPLOYEE BENEFITS		GENERATIONS HC NETWORK, LLC	2,330	2,330
29	V						
30	V	5	UTILITIES		GENERATIONS HC NETWORK, LLC	2,506	2,506
31	V	6	REPAIRS AND MAINT.		GENERATIONS HC NETWORK, LLC	1,449	1,449
32	V	19	PROFESSIONAL FEES		GENERATIONS HC NETWORK, LLC	374	374
33	V	21	CLERICAL & GENERAL		GENERATIONS HC NETWORK, LLC	133	133
34	V	26	INSURANCE		GENERATIONS HC NETWORK, LLC	310	310
35	V	30	DEPRECIATION		GENERATIONS HC NETWORK, LLC	6,734	6,734
36	V	32	INTEREST		GENERATIONS HC NETWORK, LLC	6,104	6,104
37	V	33	REAL ESTATE TAXES		GENERATIONS HC NETWORK, LLC	9,701	9,701
38	V						
39	Total		\$ 50,310			\$ 271,927	\$ * 221,617

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	06 Maintenance	\$	MAC Rx, LLC		\$	\$
16	V	10 Nursing and Medical Records	47,451	MAC Rx, LLC		43,361	(4,090)
17	V	10A Therapy		MAC Rx, LLC			
18	V	19 Professional Services		MAC Rx, LLC			
19	V	21 Clerical & General Office Expenses	1,444	MAC Rx, LLC		1,319	(124)
20	V	22 Employee Benefits	3,696	MAC Rx, LLC		3,377	(319)
21	V	39 Ancillary	328,896	MAC Rx, LLC		300,550	(28,346)
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 381,487			\$ 348,608	\$ * (32,879)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Big Ten Supply, LLC	100.00%	\$	\$
16	V	3 Housekeeping	41,206	Big Ten Supply, LLC	100.00%	37,260	(3,946)
17	V	4 Laundry	5,099	Big Ten Supply, LLC	100.00%	4,611	(488)
18	V	6 Repairs & Maintenance	4,479	Big Ten Supply, LLC	100.00%	4,050	(429)
19	V	10 Nursing And Medical Records	132,822	Big Ten Supply, LLC	100.00%	120,103	(12,719)
20	V	10A Therapy	1,179	Big Ten Supply, LLC	100.00%	1,066	(113)
21	V	21 Clerical & General		Big Ten Supply, LLC	100.00%		
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 184,786			\$ 167,091	\$ * (17,695)

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

Facility Name & ID Number

Generations At Regency Llc

0049841

Report Period Beginning:

01/01/18

Ending:

12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number

Generations At Regency Llc

0049841

Report Period Beginning:

01/01/18

Ending:

12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number

Generations At Regency Llc

0049841

Report Period Beginning:

01/01/18

Ending:

12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number

Generations At Regency Llc

0049841

Report Period Beginning:

01/01/18

Ending:

12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number

Generations At Regency Llc

0049841

Report Period Beginning:

01/01/18

Ending:

12/31/18

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1	Bryan Barrish	Relative	Administrative	0.00%	See Attached	2.97	7.43%	Alloc Salary	\$ 21,219	17-7	1	
2	Sarah Barrish	Relative	Administrative	0.00%	See Attached	4.24	8.49%	Alloc Salary	10,672	17-7	2	
3	Clark Collins	Relative	Administrative	0.00%	See Attached	2.61	6.54%	Alloc Salary	3,268	Various	3	
4	Michael Giannini	Relative	Administrative	0.00%	See Attached	2.97	7.43%	Alloc Salary	15,345	17-7	4	
5	Nenita Guzman	Relative	Dietary	0.00%	See Attached	4.24	8.49%	Alloc Salary	8,291	1-7	5	
6	Kirsten Schloss	Relative	Maintenance	0.00%	See Attached	3.39	8.49%	Alloc Salary	8,753	6-7	6	
7	Tom Winter	Relative	Administrative	0.00%	See Attached	5.09	8.49%	Alloc Salary	21,219	17-7	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	\$ 88,767		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 Llc

0049841 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Generations At Regency Llc

0049841

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	REPAIRS AND MAINT.	PATIENT DAYS	813,429	20	\$ 193,743	\$ 103,385	\$ 69,039	\$ 16,444	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	813,429	20	17,260		69,039	1,465	2
3	9	MEDICAL DIRECTOR CONSUL	PATIENT DAYS	813,429	20			69,039		3
4	10	NURSING	PATIENT DAYS	813,429	20	501,001	501,001	69,039	42,522	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	813,429	20	83,773		69,039	7,110	5
6	17	ADMINISTRATIVE	PATIENT DAYS	813,429	20	390,351	390,351	69,039	33,131	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	813,429	20	155,641		69,039	13,210	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	813,429	20	1,590		69,039	135	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	813,429	20	2,195,251	1,959,905	69,039	186,320	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	813,429	20	3,956		69,039	336	10
11	25	OTHER ADMIN. STAFF TRANS.	PATIENT DAYS	813,429	20	252,011		69,039	21,389	11
12	26	INSURANCE	PATIENT DAYS	813,429	20	21,989		69,039	1,866	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	813,429	20	138,692		69,039	11,771	13
14	32	INTEREST	PATIENT DAYS	813,429	20	(411,674)		69,039	(34,940)	14
15	35	AUTO RENTAL	PATIENT DAYS	813,429	20	47,983		69,039	4,073	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	813,429	20	11,512		69,039	977	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,603,079	\$ 2,954,641		\$ 305,809	25

Facility Name & ID Number Generations At Regency Llc

0049841

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY SALARIES	PATIENT DAYS	813,429	20	\$ 97,690	\$ 97,690	69,039	\$ 8,291	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	813,429	20	16,359	69,039	69,039	1,388	2
3	10	NURSING SALARIES	PATIENT DAYS	813,429	20	110,913	110,913	69,039	9,414	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	813,429	20	18,452	69,039	69,039	1,566	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	813,429	20	1,717,366	1,717,366	69,039	145,760	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	813,429	20	203,820	69,039	69,039	17,299	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	813,429	20	401,962	69,039	69,039	34,116	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	284,688	14	190,531	190,531	14,400	9,637	10
11	15	EMPLOYEE BENEFITS	SPECIAL REHAB INC.	284,688	14	31,950	14,400	14,400	1,616	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	368,277	19	453,836	453,836	10,710	13,198	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	368,277	19	80,131	10,710	10,710	2,330	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	20	29,526	1,093	1,093	2,506	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	20	17,073	1,093	1,093	1,449	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	20	4,403	1,093	1,093	374	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	20	1,572	1,093	1,093	133	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	20	3,650	1,093	1,093	310	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	20	79,352	1,093	1,093	6,734	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	20	71,924	1,093	1,093	6,104	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	20	114,307	1,093	1,093	9,701	23
24										24
25	TOTALS					\$ 3,644,817	\$ 2,570,336		\$ 271,927	25

Facility Name & ID Number Generations At Regency Llc

0049841

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

MAC Rx, LLC

Street Address

2307 S. Mount Prospect Road

City / State / Zip Code

Des Plaines, IL 60018

Phone Number

(224)220-2700

Fax Number

(224)220-2730

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	06	Maintenance	Direct Allocation		\$	\$		\$	1
2	10	Nursing And Medical Records	Direct Allocation					43,361	2
3	10A	Therapy	Direct Allocation						3
4	19	Professional Services	Direct Allocation						4
5	21	Clerical & General Office Expense	Direct Allocation					1,319	5
6	22	Employee Benefits	Direct Allocation					3,377	6
7	39	Ancillary	Direct Allocation					300,550	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				\$	\$		\$	348,608

Facility Name & ID Number Generations At Regency Llc

0049841

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Big Ten Supply, LLC

Street Address

15632 West Sprucewood Lane

City / State / Zip Code

Libertyville, IL 60048

Phone Number

(312)502-5882

Fax Number

(847)816-3425

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation		\$	\$		\$	1
2	3	Housekeeping	Direct Allocation					37,260	2
3	4	Laundry	Direct Allocation					4,611	3
4	6	Repairs & Maintenance	Direct Allocation					4,050	4
5	10	Nursing And Medical Records	Direct Allocation					120,103	5
6	10A	Therapy	Direct Allocation					1,066	6
7	21	Clerical & General	Direct Allocation						7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	167,091

Facility Name & ID Number Generations At Regency Llc

0049841

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Generations At Regency Llc

0049841

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Generations At Regency Llc

0049841

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Generations At Regency Llc

0049841

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Generations At Regency Llc

0049841 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number

Generations At Regency Llc

0049841

Report Period Beginning:

01/01/18

Ending:

12/31/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	HUD		X	Mortgage			\$	\$ 23,981,255		\$ 844,135	1									
2	1st Source Bank		X	Vehicle Note				20,188		1,195	2									
3											3									
4											4									
5											5									
Working Capital																				
6	Lake Forest Bank		X	Line of Credit				2,015,000		101,873	6									
7	Shareholder Loans	X		Related Party Loan				2,170,000		55,460	7									
8	See Supplemental Schedule									(55,460)	8									
9	TOTAL Facility Related						\$	\$ 28,186,443		\$ 947,203	9									
B. Non-Facility Related*																				
10	Interest Income		X							(8,399)	10									
11	Interest Income- Bldg Co		X							(261)	11									
12	Allocated From Generations HN		X							(28,836)	12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$ (37,496)	14									
15	TOTALS (line 9+line14)						\$	\$ 28,186,443		\$ 909,707	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 154,555 Line # 36

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

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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Generations At Regency Llc COUNTY Cook
 FACILITY IDPH LICENSE NUMBER 0049841
 CONTACT PERSON REGARDING THIS REPORT _____
 TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) <u>Tax</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>899,389.48</u>	\$ <u>888,461.90</u>
2. <u>See Attached</u>	<u>SIR Training</u>	\$ <u>899,389.48</u>	\$ <u>463.69</u>
3. <u>See Attached</u>	<u>Allocated From SIR Properties</u>	\$ <u>137,812.17</u>	\$ <u>9,159.54</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>1,936,591.13</u></u>	\$ <u><u>898,085.13</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2017 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

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

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Generations At Regency Llc COUNTY Cook
 FACILITY IDPH LICENSE NUMBER 0049841
 CONTACT PERSON REGARDING THIS REPORT _____
 TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. Summary of Real Estate Tax Cost

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

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

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).

Generations Healthcare Network Training Center- Separate Building

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2009</u>	<u>\$ 950,000</u>	1
2					2
3	TOTALS			\$ 950,000	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	\$ 13,150,000	\$ 700,449	39	\$ 337,179	\$ (363,270)	\$ 2,941,389	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		2008	252,676		20	11,834	11,834	145,227	9
10	Various		2009	547,020		20	42,817	42,817	257,143	10
11	Various		2010	392,518		20	20,023	20,023	171,757	11
12	Various		2011	827,017		20	40,638	40,638	331,983	12
13	Various		2012	124,944		20	6,457	6,457	41,369	13
14	Various		2013	276,905		20	13,845	13,845	78,436	14
15	Various		2014	51,349		20	2,567	2,567	12,265	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

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		8,373,643			418,682	418,682	3,365,761	67
68		151,665		3,295	4,823	1,528	95,272	68
69				150,090		(150,090)		69
70		\$ 24,147,737	\$ 853,834		\$ 898,868	\$ 45,034	\$ 7,440,601	70

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

Facility Name & ID Number Generations At Regency Llc

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 24,147,737	\$ 853,834		\$ 898,868	\$ 45,034	\$ 7,440,601	1
2	Video Camera & Monitors	2015	2,792		20	140	140	430	2
3	Freight Elevator - Replace Defective Board	2015	2,971		20	149	149	508	3
4	Hvac Coiled Replacement	2016	16,785		20	839	839	1,818	4
5	Elevator-Pump Unit	2016	13,790		20	690	690	1,436	5
6	Parking Lot - Install/Compact 2 Traffic Control Bumps	2016	3,150		20	158	158	341	6
7	Underground Plumbing Repair To Sanitary Drain For Dietary Area	2016	2,500		20	125	125	281	7
8	Removal And Replacement Of Concrete Ramp	2018	11,457		20	286	286	286	8
9	Delay Egress	2018	4,870		20	122	122	122	9
10	Walk-In Cooler Door	2018	5,417		20	68	68	68	10
11	Replace Packing On Passenger Elevator	2018	2,950		20	148	148	148	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)		\$ 24,214,419	\$ 853,834		\$ 901,591	\$ 47,757	\$ 7,446,040	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 24,214,419	\$ 853,834		\$ 901,591	\$ 47,757	\$ 7,446,040	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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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)		\$ 24,214,419	\$ 853,834		\$ 901,591	\$ 47,757	\$ 7,446,040	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 24,214,419	\$ 853,834		\$ 901,591	\$ 47,757	\$ 7,446,040	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)		\$ 24,214,419	\$ 853,834		\$ 901,591	\$ 47,757	\$ 7,446,040	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 24,214,419	\$ 853,834		\$ 901,591	\$ 47,757	\$ 7,446,040	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)		\$ 24,214,419	\$ 853,834		\$ 901,591	\$ 47,757	\$ 7,446,040	34

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

Facility Name & ID Number Generations At Regency Llc

0049841

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Various	2009	818,516		20	40,926	40,926	409,260	9
10	Various	2010	518,211		20	25,910	25,910	233,194	10
11	Ist Floor Resident Room Work	2011	4,500		20	225	225	1,800	11
12	PT Recovery Room	2011	4,000		20	200	200	1,600	12
13	Dialysis Water Purification	2011	6,385		20	319	319	2,554	13
14	Custom Cabinets	2011	4,000		20	200	200	1,600	14
15	Grocery Cabinets	2011	7,900		20	395	395	3,160	15
16	Outdoor Iron Gates and Fencing	2011	9,245		20	462	462	3,698	16
17	Sump Pump	2011	7,342		20	367	367	2,937	17
18	Landscape Improvements - Trees & Plants	2011	11,340		20	567	567	4,536	18
19	Ist Floor Suites - Cabinets & Granite Tops	2011	28,700		20	1,435	1,435	11,480	19
20	Cabinetry	2011	8,600		20	430	430	3,440	20
21	Window Treatment	2011	11,587		20	579	579	4,634	21
22	Window Treatment	2011	19,302		20	965	965	7,721	22
23	Window Treatments	2011	3,003		20	150	150	1,201	23
24	Cubicle Curtains - Dialysis	2011	7,051		20	353	353	2,821	24
25	Install Corner Guards	2011	3,840		20	192	192	1,536	25
26	Kitchen Dishwasher Install	2011	5,306		20	265	265	2,122	26
27	Family Room Wall Prep & Paint	2011	2,700		20	135	135	1,080	27
28	Mason Wall for Garbage Enclosure	2011	6,500		20	325	325	2,600	28
29	Dialysis, Therapy, & Dining Rooms & Ist Flr & Basement Remodel	2011	5,662,788		20	283,139	283,139	2,265,114	29
30	Architect Fees-Dialysis, Therapy&Dining Rooms&Ist Flr&Baseme	2011	479,093		20	23,955	23,955	191,638	30
31	Fees Dialysis, Therapy & Dining Rooms & Ist Flr & Basement Rem	2011	299,630		20	14,982	14,982	119,853	31
32	Contracter Fee - Dialysis, Therapy & Dining Rooms & Ist Flr & Ba	2011	36,491		20	1,825	1,825	14,597	32
33	Administrative Offices	2009	250,000		20	12,500	12,500	50,000	33
34	TOTAL (lines 1 thru 33)		\$ 8,216,030	\$		\$ 410,801	\$ 410,801	\$ 3,344,176	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 8,216,030	\$		\$ 410,801	\$ 410,801	\$ 3,344,176	1
2	Walk-in Freezer Work	2015	8,484		20	424	424	1,696	2
3	Door to Walk-in Freezer	2015	4,767		20	238	238	953	3
4	Wireless Network Upgrade	2015	15,589		20	779	779	3,117	4
5	Custom Elevator Pit Ladder	2015	10,665		20	533	533	2,133	5
6	Parking Lot Re-Stripe	2015	7,400		20	370	370	1,480	6
7	Stairwell Safety Signs	2015	2,591		20	130	130	519	7
8	Thru Wall Air Conditioners	2015	4,207		20	210	210	841	8
9	LED Lighting	2016	24,258		20	1,213	1,213	3,639	9
10	Outdoor Sign	2016	7,655		20	383	383	1,149	10
11	Privacy Curtains 3rd and 4th floors	2016	2,974		20	149	149	446	11
12	100 Amp Sub Panels- Basement Electrical Room and Linen Closet	2017	11,800		20	590	590	1,180	12
13	Elevator- Control Boards/Selector Replacement	2017	4,184		20	209	209	418	13
14	ATS Switch on GeneratorRetrofit Power Panel and Controller	2017	9,368		20	468	468	936	14
15	Tuckpointing/Lintel/Flashing Repair-Floors 1-4 North Facing Bldg	2017	13,240		20	662	662	1,324	15
16	Freight Elevator- Repair Detector Edge and Control Panel	2017	4,641		20	232	232	464	16
17	Wiring and Circuit Breakers	2018	12,000		20	600	600	600	17
18	Elevator #1 Pump Unit	2018	13,790		20	690	690	690	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)		\$ 8,373,643	\$		\$ 418,682	\$	\$ 3,365,761	34

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

Facility Name & ID Number Generations At Regency Llc

0049841

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Related Party								1
2	Buildings:								2
3	Allocated from Generations Healthcare Network, LLC	2009	21,217	572	39	544	(28)	4,919	3
4	Allocated from S.I.R. Properties/GHN	1993	38,416	1,220	35	1,098	(122)	27,988	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Generations Healthcare Network, LLC	1993	9,740	271	20		(271)	9,740	9
10	Allocated from Generations Healthcare Network, LLC	1994	30		20			30	10
11	Allocated from Generations Healthcare Network, LLC	1995	223		20			223	11
12	Allocated from Generations Healthcare Network, LLC	1997	14,966	335	20		(335)	14,966	12
13	Allocated from Generations Healthcare Network, LLC	1999	1,177		20	59	59	1,132	13
14	Allocated from Generations Healthcare Network, LLC	1999							14
15	Allocated from Generations Healthcare Network, LLC	2000	1,389		20	69	69	1,288	15
16	Allocated from Generations Healthcare Network, LLC	2007	4,464		20	223	223	2,498	16
17	Allocated from Generations Healthcare Network, LLC	2008	12,302	236	20	455	219	8,088	17
18	Allocated from Generations Healthcare Network, LLC	2009	30,570	280	20	1,528	1,249	14,130	18
19	Allocated from Generations Healthcare Network, LLC	2011	756	76	20	76		561	19
20	Allocated from Generations Healthcare Network, LLC	2012	2,420	121	20	121		777	20
21	Allocated from Generations Healthcare Network, LLC	2014	339	34	20	17	(17)	78	21
22	Allocated from Generations Healthcare Network, LLC	2016	441	22	20	22		53	22
23	Allocated from Generations Healthcare Network, LLC	2018							23
24									24
25	Allocated from S.I.R. Properties/GHN	2012	2,353	103	20	118	15	707	25
26	Allocated from S.I.R. Properties/GHN	2010	2,318		20	116	116	966	26
27	Allocated from S.I.R. Properties/GHN	2009	2,307		20	115	115	1,130	27
28	Allocated from S.I.R. Properties/GHN	2007	227	13	20	11	(2)	136	28
29	Allocated from S.I.R. Properties/GHN	2002	152		20	8	8	126	29
30	Allocated from S.I.R. Properties/GHN	1999	4,868		20	243	243	4,746	30
31	Allocated from S.I.R. Properties/GHN	1994	366	9	20		(9)	366	31
32	Allocated from S.I.R. Properties/GHN	1993	623	3	20		(3)	623	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 151,665	\$ 3,295		\$ 4,823	\$ 1,528	\$ 95,272	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 151,665	\$ 3,295		\$ 4,823	\$ 1,528	\$ 95,272	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 151,665	\$ 3,295		\$ 4,823	\$ 1,528	\$ 95,272	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	\$ 1,539,049	\$ 2,968	\$ 153,943	\$ 150,975	10	\$ 1,261,884	71
72	Current Year Purchases	8,750	68	851	783	10	851	72
73	Fully Depreciated Assets	128,549		563	563	10	128,549	73
74								74
75	TOTALS	\$ 1,676,347	\$ 3,036	\$ 155,357	\$ 152,321		\$ 1,391,283	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	\$	\$ 5,531	\$ 5,531	5	\$ 15,556	76
77		Allocated from Generations Health	2018	6,393	403	481	78	5	2,973	77
78										78
79										79
80	TOTALS			\$ 53,294	\$ 403	\$ 6,012	\$ 5,609		\$ 18,529	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 26,894,060	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 857,273	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,062,960	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 205,687	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,855,853	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	\$ 500,000	\$	\$	86
87	Land- Vacant Parcel - 2009	400,000			87
88	Land- Office Buidling - 2009	150,000			88
89	Tuckpointing/Linel/Flashing - 2017	6,620			89
90					90
91	TOTALS	\$ 1,056,620	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Resident Communication	\$ 88,353	92
93	System		93
94			94
95		\$ 88,353	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2019 \$ _____

13. _____ /2020 \$ _____

14. _____ /2021 \$ _____

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

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

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 4,691 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Allocated From Generations Healthcare Network</u>		\$	\$ <u>4,073</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>4,073</u>	21

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

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

Facility Name & ID Number Generations At Regency Llc # 0049841 Report Period Beginning: 01/01/18 Ending: 12/31/18
 XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	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	\$		\$ 498,340	\$		\$ 498,340	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			129,139			129,139	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			579,611			579,611	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				346,222		346,222	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					298,568	44,669		343,237	13
14	TOTAL			\$		\$ 1,505,658	\$ 390,891		\$ 1,896,549	14

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

Facility Name & ID Number Generations At Regency Llc

0049841

Report Period Beginning: 01/01/18

Ending:

12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 66,743	\$ 146,616	1
2	Cash-Patient Deposits	80,273	80,273	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,994,038	3,994,038	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	80,914	199,137	6
7	Other Prepaid Expenses	6,754	6,754	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule		904,175	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,228,722	\$ 5,330,993	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		19,849,155	14
15	Leasehold Improvements, at Historical Cost	2,289,732	3,967,354	15
16	Equipment, at Historical Cost	630,341	1,730,383	16
17	Accumulated Depreciation (book methods)	(1,303,112)	(7,148,172)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	88,353	8,434,441	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,705,314	\$ 28,333,161	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,934,036	\$ 33,664,154	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,869,715	\$ 1,869,716	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	80,333	80,333	28
29	Short-Term Notes Payable	4,193,045	4,193,045	29
30	Accrued Salaries Payable	411,962	411,962	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,180	17,180	31
32	Accrued Real Estate Taxes(Sch.IX-B)		944,500	32
33	Accrued Interest Payable		70,945	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Attached Schedule	59,887	61,887	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,632,122	\$ 7,649,568	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	12,143	12,143	39
40	Mortgage Payable		23,981,255	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	See Attached Schedule		2,510,000	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 12,143	\$ 26,503,398	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,644,265	\$ 34,152,966	46
47	TOTAL EQUITY(page 18, line 24)	\$ (710,229)	\$ (488,812)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,934,036	\$ 33,664,154	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 613,936	1
2	Restatements (describe):		2
3	<u>Rounding</u>	<u>6</u>	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 613,942	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	<u>(1,324,171)</u>	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,324,171)	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)	\$ (710,229)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Generations At Regency Llc

0049841

Report Period Beginning: 01/01/18

Ending: 12/31/18

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

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

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 15,543,284	1
2	Discounts and Allowances for all Levels	(3,340,412)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,202,872	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,376,119	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,376,119	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	338,860	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,143	19
20	Radiology and X-Ray	13,211	20
21	Other Medical Services	54,931	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 434,145	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	8,399	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,399	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	9,360	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,360	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 17,030,895	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,646,257	31
32	Health Care	6,857,194	32
33	General Administration	3,159,027	33
B. Capital Expense			
34	Ownership	3,261,332	34
C. Ancillary Expense			
35	Special Cost Centers	1,896,674	35
36	Provider Participation Fee	534,582	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 18,355,066	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,324,171)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,324,171)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 2,521,007	44
45	Private Pay - Net Inpatient Revenue	1,448,741	45
46	Medicare - Net Inpatient Revenue	1,017,338	46
47	Other-(specify) <u>Managed Care, Insurance</u>	6,763,320	47
48	Other-(specify) <u>Hospice</u>	452,466	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 12,202,872	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Generations At Regency Llc

0049841

Report Period Beginning:

01/01/18

Ending:

12/31/18

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,829	1,960	\$ 122,247	\$ 62.37	1
2	Assistant Director of Nursing	1,909	2,086	85,931	41.19	2
3	Registered Nurses	47,177	51,121	1,612,397	31.54	3
4	Licensed Practical Nurses	34,796	36,980	1,030,225	27.86	4
5	CNAs & Orderlies	106,462	113,988	1,602,826	14.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,199	10,270	203,512	19.82	8
9	Activity Director					9
10	Activity Assistants	19,542	20,727	248,712	12.00	10
11	Social Service Workers	15,031	16,137	295,877	18.34	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	41,524	45,131	573,049	12.70	15
16	Dishwashers					16
17	Maintenance Workers	6,902	7,748	170,724	22.03	17
18	Housekeepers	31,618	34,190	391,566	11.45	18
19	Laundry	2,761	2,968	33,667	11.34	19
20	Administrator	1,858	1,965	107,286	54.60	20
21	Assistant Administrator	1,890	2,086	85,941	41.20	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,003	8,575	164,998	19.24	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	7,683	8,301	240,908	29.02	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	3,725	4,137	94,021	22.73	33
34	TOTAL (lines 1 - 33)	341,909	368,370	\$ 7,063,887 *	\$ 19.18	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	\$ 59,725	01-03	35
36	Medical Director	Monthly	90,000	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	14,848	10-03	39
40	Physical Therapy Consultant	194	9,702	10a-03	40
41	Occupational Therapy Consultant	105	5,217	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	41	1,973	10a-03	43
44	Activity Consultant	Monthly	6,662	11-03	44
45	Social Service Consultant	Monthly	4,300	12-03	45
46	Other(specify) <u>Telemedicine</u>	Monthly	35,500	10-03	46
47	<u>Psychiatric</u>	Monthly	2,400	12-03	47
48	<u>Special Rehab</u>	Monthly	14,400	10A-03	48
49	TOTAL (lines 35 - 48)	340	\$ 343,127		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	8	\$ 255	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	30,570	718,180	10-03	52
53	TOTAL (lines 50 - 52)	30,578	\$ 718,435		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions					
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount				
Javier, Joseph	Administrator	0	\$ 107,286	Workers' Compensation Insurance	\$ 142,474	IDPH License Fee	\$ 1,992				
Radunsky, Lea	Asst. Administrator	0	85,941	Unemployment Compensation Insurance	33,028	Advertising: Employee Recruitment	5,174				
				FICA Taxes	527,864	Health Care Worker Background Check	3,410				
				Employee Health Insurance	457,094	(Indicate # of checks performed 341)					
				Employee Meals	36,628	Patient Background Checks					
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	16,646				
				Employee Benefits - Other	34,097	Licenses & Permits	6,367				
				401K Matching Contr.	9,060	Allocated From Generations	135				
				Allocated from MAC Rx	(319)						
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 193,227	TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,239,926	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 33,724	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**				
Description			Amount	Description			Line #	Amount	Description		Amount
GHN - Dir. of Administrative Services			\$ 100,800						Out-of-State Travel		\$
GHN - Ancillary Administrative Charges			90,000						In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 190,800	TOTAL				\$	Seminar Expense		2,795
C. Professional Services									Allocated From Generations		336
Vendor/Payee	Type	Amount							Entertainment Expense		()
Generations Healthcare Network	Bookkeeping	\$ 198,000							(agree to Sch. V, line 24, col. 8)		
Generations Healthcare Network	Computer Support Services	46,800							TOTAL		\$ 3,131
See Attached	Legal Fees	13,867									
Markoff	Collection Fees- Adj- Pg 5A	9,186									
Paychex	Payroll Processing	18,384									
Personnel Planners	Unemployment Consulting	1,980									
Generations Healthcare Network	Director of Financial Services	54,000									
Generations Healthcare Network	Dir. of Information Technology	21,600									
Generations Healthcare Network	Director- Regulatory Services	32,400									
Generations Healthcare Network	Director of Bus Development	216,000									
Plante Moran	Accounting	5,461									
See Supplemental Schedule		54,996									
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 672,674								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Generations At Regency Llc

0049841

Report Period Beginning:

01/01/18

Ending: 12/31/18

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. HCCI - \$25,613.25
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 54,787 Line 10-02
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 534,582
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 36,628 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees