

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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>01/01/20</u> to <u>12/31/20</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: _____																									
Date of Initial License for Current Owners: <u>1/1/2008</u>		<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) _____ <u>05/21/2021</u> * Subject to the attached Accountants' Consulting Report (Date)</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name <u>Steven N. Lavenda, CPA</u> and Title) <u>Partner</u></td></tr><tr><td>(Firm Name <u>Marcum, LLP</u> & Address) <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u></td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____ <u>05/21/2021</u> * Subject to the attached Accountants' Consulting Report (Date)	Paid Preparer	(Print Name <u>Steven N. Lavenda, CPA</u> and Title) <u>Partner</u>	(Firm Name <u>Marcum, LLP</u> & Address) <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u>	(Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>	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												
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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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☐ Charitable Corp.	☐ Individual	☐ State																							
☐ Trust	☐ Partnership	☐ County																							
IRS Exemption Code _____	☐ Corporation	☐ Other _____																							
	☐ "Sub-S" Corp.																								
	☒ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>Steven N. Lavenda</u>																									
Telephone Number: <u>(847) 282-6300</u>																									
Email Address: _____																									

Facility Name & ID Number

Generations at Regency

#0049841Report Period Beginning:01/01/20Ending:12/31/20

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
2		Skilled Pediatric (SNF/PED)		
3		Intermediate (ICF)		
4		Intermediate/DD		
5		Sheltered Care (SC)		
6		ICF/DD 16 or Less		
7	300	TOTALS	300	109,800

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	50,942	5,744	10,533	67,219
9	SNF/PED				
10	ICF				
11	ICF/DD				
12	SC				
13	DD 16 OR LESS				
14	TOTALS	50,942	5,744	10,533	67,219

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

61.22%

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

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

7,332

Medicare Intermediary

National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL

X

MODIFIED CASH*CASH*

Is your fiscal year identical to your tax year?

YES

X

NO

Tax Year:

12/31/20

Fiscal Year:

12/31/20

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

Facility Name & ID Number Generations at Regency # 0049841 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	618,779	60,363	76,494	755,636		755,636	(32,881)	722,755			1
2	Food Purchase		425,472		425,472	(31,952)	393,520	(4,151)	389,369			2
3	Housekeeping	422,292	68,952		491,244		491,244	(6,014)	485,230			3
4	Laundry	54,608	12,108	227,330	294,046		294,046	(198)	293,848			4
5	Heat and Other Utilities			247,561	247,561		247,561	1,519	249,080			5
6	Maintenance	181,132	54,266	243,825	479,223		479,223	(85,042)	394,181			6
7	Other (specify):*							4,681	4,681			7
8	TOTAL General Services	1,276,811	621,161	795,210	2,693,182	(31,952)	2,661,230	(122,086)	2,539,144			8
	B. Health Care and Programs											
9	Medical Director			39,000	39,000		39,000		39,000			9
10	Nursing and Medical Records	5,262,451	484,836	1,535,587	7,282,874		7,282,874	(67,247)	7,215,627			10
10a	Therapy	188,518	12,308	39,035	239,861		239,861	(4,943)	234,918			10a
11	Activities	193,631	7,260	5,096	205,987		205,987		205,987			11
12	Social Services	224,297		3,680	227,977		227,977		227,977			12
13	CNA Training											13
14	Program Transportation			2,612	2,612		2,612		2,612			14
15	Other (specify):*							16,513	16,513			15
16	TOTAL Health Care and Programs	5,868,897	504,404	1,625,010	7,998,311		7,998,311	(55,677)	7,942,634			16
	C. General Administration											
17	Administrative	246,398		201,600	447,998		447,998	(4,408)	443,590			17
18	Directors Fees											18
19	Professional Services			984,044	984,044	(20,433)	963,611	(740,952)	222,659			19
20	Dues, Fees, Subscriptions & Promotions			116,985	116,985		116,985	(64,153)	52,832			20
21	Clerical & General Office Expenses	64,071	37,705	514,048	615,824		615,824	(124,740)	491,084			21
22	Employee Benefits & Payroll Taxes			1,489,500	1,489,500	31,952	1,521,452	(602)	1,520,850			22
23	Inservice Training & Education											23
24	Travel and Seminar			782	782		782	508	1,290			24
25	Other Admin. Staff Transportation			2,321	2,321		2,321	9,106	11,427			25
26	Insurance-Prop.Liab.Malpractice			300,524	300,524		300,524	30,598	331,122			26
27	Other (specify):*							69,260	69,260			27
28	TOTAL General Administration	310,469	37,705	3,609,804	3,957,978	11,518	3,969,496	(825,383)	3,144,114			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,456,177	1,163,270	6,030,024	14,649,471	(20,433)	14,629,038	(1,003,146)	13,625,891			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			140,670	140,670		140,670	932,724	1,073,394			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			145,875	145,875		145,875	722,282	868,157			32
33	Real Estate Taxes					20,433	20,433	699,786	720,220			33
34	Rent-Facility & Grounds			2,616,000	2,616,000		2,616,000	(2,616,000)				34
35	Rent-Equipment & Vehicles			3,115	3,115		3,115	6,655	9,770			35
36	Other (specify):*							148,501	148,501			36
37	TOTAL Ownership			2,905,660	2,905,660	20,433	2,926,093	(106,051)	2,820,042			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	367,076	427,852	1,822,535	2,617,463		2,617,463	(39,247)	2,578,216			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			523,947	523,947		523,947		523,947			42
43	Other (specify):*			5,044	5,044		5,044	(5,044)				43
44	TOTAL Special Cost Centers	367,076	427,852	2,351,526	3,146,454		3,146,454	(44,291)	3,102,163			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,823,253	1,591,122	11,287,210	20,701,585		20,701,585	(1,153,488)	19,548,097			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(3,033)	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	283,465	30		9
10	Interest and Other Investment Income	(16,361)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(364)	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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(352,980)	21		24
25	Fund Raising, Advertising and Promotional	(30,975)	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	(299,785)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (420,033)		\$	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)	(733,455)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (733,455)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,153,488)		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	Sequestration Expense	\$ (29,473)	21	1
2	Chamber of Commerce	(1,200)	20	2
3	Bank Fees	(11,819)	21	3
4	Credit Card Fees	(337)	21	4
5	Theft & Damage Loss	(1,914)	21	5
6	Marketing	(125)	43	6
7	Brokerage Fees	(2,960)	19	7
8	PAC Dues	(10,500)	20	8
9	Annual Report	(256)	20	9
10	Line of Credit Fees	(750)	20	10
11	Non-Allowable Portion of R/E Tax Bill	(14,521)	33	11
12	Out of Period Dues	(24,453)	20	12
13	Prior Year Nursing Supplie Expense	(14,044)	10	13
14	Website Costs	(2,011)	19	14
15	Bldg Co. - Capitalized R&M	(88,353)	06	15
16	Public Relations	(4,919)	43	16
17	Collections	(10,075)	21	17
18	Non-Allowable Legal Fees	(20,375)	19	18
19	Non-Allowable Interest	(74,300)	32	19
20	2020 Professional Fees not expensed in 2020	12,600	19	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	(299,785)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Generations at Regency

0049841

Report Period Beginning:

01/01/20

Ending:

12/31/20

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				(31,934)		(947)						(32,881)	1
2	Food Purchase	(364)		(3,787)									(4,151)	2
3	Housekeeping						(6,014)						(6,014)	3
4	Laundry						(198)						(198)	4
5	Heat and Other Utilities	(3,033)	2,299		2,253								1,519	5
6	Maintenance	(88,353)	13,312	(11,799)	2,074		(276)						(85,042)	6
7	Other (specify):*			2,325	2,356								4,681	7
8	TOTAL General Services	(91,750)	15,611	(13,261)	(25,251)		(7,435)						(122,086)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(14,044)		(15,673)		(6,587)	(30,943)						(67,247)	10
10a	Therapy						(4,943)						(4,943)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			16,513									16,513	15
16	TOTAL Health Care and Programs	(14,044)		840		(6,587)	(35,886)						(55,677)	16
	C. General Administration													
17	Administrative			(173,524)	169,116								(4,408)	17
18	Directors Fees													18
19	Professional Services	(12,746)		(745,631)	17,425								(740,952)	19
20	Fees, Subscriptions & Promotions	(68,134)		3,981									(64,153)	20
21	Clerical & General Office Expenses	(406,599)		281,775	142	(59)							(124,740)	21
22	Employee Benefits & Payroll Taxes					(602)							(602)	22
23	Inservice Training & Education													23
24	Travel and Seminar			508									508	24
25	Other Admin. Staff Transportation			9,106									9,106	25
26	Insurance-Prop.Liab.Malpractice		27,704	2,619	275								30,598	26
27	Other (specify):*			30,048	39,212								69,260	27
28	TOTAL General Administration	(487,479)	27,704	(591,118)	226,170	(660)							(825,383)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(593,273)	43,315	(603,539)	200,919	(7,247)	(43,322)						(1,003,146)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Generations at Regency # 0049841 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	283,465	643,511		5,748								932,724	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(90,661)	811,024	(2,250)	4,169								722,282	32
33	Real Estate Taxes	(14,521)	704,313		9,994								699,786	33
34	Rent-Facility & Grounds		(2,616,000)										(2,616,000)	34
35	Rent-Equipment & Vehicles			6,655									6,655	35
36	Other (specify):*		148,501										148,501	36
37	TOTAL Ownership	178,284	(308,651)	4,405	19,911								(106,051)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(39,247)							(39,247)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(5,044)											(5,044)	43
44	TOTAL Special Cost Centers	(5,044)				(39,247)							(44,291)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(420,033)	(265,335)	(599,134)	220,830	(46,494)	(43,322)						(1,153,488)	45

VII. RELATED PARTIES

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

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

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 2,616,000	Regency Property, LLC		\$	(2,616,000)	1
2	V	32	Interest		Regency Property, LLC		811,024	811,024	2
3	V	36	MIP Expense		Regency Property, LLC		148,501	148,501	3
4	V	05	Utilities		Regency Property, LLC		2,299	2,299	4
5	V	06	Repairs and Maintenance		Regency Property, LLC		13,312	13,312	5
6	V	26	Property Insurance		Regency Property, LLC		27,704	27,704	6
7	V	33	Real Estate Taxes		Regency Property, LLC		704,313	704,313	7
8	V	30	Depreciation		Regency Property, LLC		643,511	643,511	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 2,616,000			\$ 2,350,665	\$ * (265,335)	14

* 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	REGENCY PROPERTY, LLC	LINCOLNWOOD	BUILDING CO.	1
2	BARRISH GROUP LTD PARTNERSHIP	12.15%	AUBURN VILLAGE	AUBURN, IN	GENERATIONS HEALTH NETW	LINCOLNWOOD	CONSULTING CO.	2
3	BRYAN BARRISH TRUST DTD 9/1/04	12.15%	BRYN MAWR CARE INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	JOSHUA DAVID BEHR	1.56%	DECATUR MANOR HEALTHCARE,LLC	DECATUR	OAKTON ARMS	DES PLAINES	ASSISTED LIVING	4
5	LINDSEY ERIN BEHR	1.56%	GENERATIONS AT APPLEWOOD, LLC	MATTESON	MAC Rx LLC	DES PLAINES	PHARMACY	5
6	LORI BARRISH	1.56%	GENERATIONS AT ELMWOOD PARK, INC	ELMWOOD PARK	BIG TEN SUPPLY, LLC	LIBERTYVILLE	SUPPLY CO.	6
7	MICHAEL GIANNINI TRUST DTD 3/13/00	10.42%	GENERATIONS AT LINCOLN, LLC	LINCOLN	TRANSITIONS INDIANA	HUNTLEY	HOSPICE	7
8	RALPH GESULADO	12.15%	GENERATIONS AT NEIGHBORS, LLC	BYRON	GENERATIONS AT RIVERVIEW		ASSISTED & INDEPENDENT	8
9	RALPH GESULADO CHILDREN'S TRUST	12.15%	GENERATIONS AT OAKTON PAVILION, LLC	DES PLAINES	SENIOR LIVING	EAST PEORIA	LIVING	9
10	THOMAS/STEPHANIE WINTER REV. TRUST	1.56%	GENERATIONS AT PEORIA, LLC	PEORIA				10
11			GENERATIONS AT RIVERVIEW, LLC	EAST PEORIA				11
12			GENERATIONS AT ROCK ISLAND, LLC	ROCK ISLAND				12
13			GREENWOOD CARE, INC.	EVANSTON				13
14			PRAIRIE CREEK VILLAGE, LLC	DECATUR				14
15			VILLA CLARA POST ACUTE, LLC	DECATUR				15
16			WILSON CARE, INC.	CHICAGO				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

VII. RELATED PARTIES (continued)

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

☒ X

 YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Dietary Other and Rebates	\$	Generations HC Network, LLC		\$(3,787)	\$(3,787)	15
16	V	6	Repairs & Maintenance	30,240	Generations HC Network, LLC		18,441	(11,799)	16
17	V	7	Emp. Ben. - General Svc.		Generations HC Network, LLC		2,325	2,325	17
18	V	9	Medical Director Consults		Generations HC Network, LLC				18
19	V	10	Nursing	104,160	Generations HC Network, LLC		88,487	(15,673)	19
20	V	15	Emp. Ben. - Health Care		Generations HC Network, LLC		16,513	16,513	20
21	V	17	Administrative	201,600	Generations HC Network, LLC		28,076	(173,524)	21
22	V	19	Professional Fees	756,840	Generations HC Network, LLC		11,209	(745,631)	22
23	V	20	Fee, Subscriptions		Generations HC Network, LLC		3,981	3,981	23
24	V	21	Clerical & General	60,480	Generations HC Network, LLC		342,255	281,775	24
25	V	24	Education & Seminar		Generations HC Network, LLC		508	508	25
26	V	25	Other Admin. Staff Transportation		Generations HC Network, LLC		9,106	9,106	26
27	V	26	Insurance		Generations HC Network, LLC		2,619	2,619	27
28	V	27	Emp. Ben. - Gen. Admin.		Generations HC Network, LLC		30,048	30,048	28
29	V	32	Interest		Generations HC Network, LLC		(2,250)	(2,250)	29
30	V	35	Auto Rental		Generations HC Network, LLC		5,655	5,655	30
31	V	35	Equipment Rental		Generations HC Network, LLC		1,000	1,000	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,153,320			\$ 554,186	\$ * (599,134)	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	\$ 40,320	Generations HC Network, LLC		\$ 8,386	\$ (31,934)	15
16	V	7	Emp. Ben. - Dietary		Generations HC Network, LLC		1,568	1,568	16
17	V	17	Admin./Legal Salaries		Generations HC Network, LLC		169,116	169,116	17
18	V	19	Fin. Consult./Regl. Dir.		Generations HC Network, LLC		16,876	16,876	18
19	V	27	Emp. Ben. - Administrative		Generations HC Network, LLC		39,212	39,212	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V	6	Maintenance Salaries	3,930	Generations HC Network, LLC		4,062	132	25
26	V	7	Employee Benefits		Generations HC Network, LLC		788	788	26
27	V								27
28	V	5	Utilities		Generations HC Network, LLC		2,253	2,253	28
29	V	6	Repairs & Maintenance		Generations HC Network, LLC		1,942	1,942	29
30	V	19	Professional Fees		Generations HC Network, LLC		549	549	30
31	V	21	Clerical & General		Generations HC Network, LLC		142	142	31
32	V	26	Insurance		Generations HC Network, LLC		275	275	32
33	V	30	Depreciation		Generations HC Network, LLC		5,748	5,748	33
34	V	32	Interest		Generations HC Network, LLC		4,169	4,169	34
35	V	33	Real Estate Taxes		Generations HC Network, LLC		9,994	9,994	35
36	V								36
37	V								37
38	V								38
39	Total			\$ 44,250			\$ 265,080	\$ * 220,830	39

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

VII. RELATED PARTIES (continued)

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

X YES NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	\$ 70,480	MAC Rx, LLC		\$ 63,893	\$ (6,587)	15
16	V	21	Clerical & General Office Expenses	629	MAC Rx, LLC		570	(59)	16
17	V	22	Employee Benefits	6,437	MAC Rx, LLC		5,836	(602)	17
18	V	39	Ancillary	419,942	MAC Rx, LLC		380,695	(39,247)	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			\$ 497,488			\$ 450,994	\$ * (46,494)	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	\$ 9,858	Big Ten Supply, LLC		\$ 8,910	\$ (947)	15
16	V	3	Housekeeping	62,570	Big Ten Supply, LLC		56,556	(6,014)	16
17	V	4	Laundry	2,062	Big Ten Supply, LLC		1,864	(198)	17
18	V	6	Repairs & Maintenance	2,871	Big Ten Supply, LLC		2,595	(276)	18
19	V	10	Nursing And Medical Records	321,944	Big Ten Supply, LLC		291,001	(30,943)	19
20	V	10A	Therapy	51,426	Big Ten Supply, LLC		46,483	(4,943)	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			\$ 450,731			\$ 407,409	\$ * (43,322)	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 (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 (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 (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 (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.

Facility Name & ID Number Generations at Regency # **0049841** Report Period Beginning: 01/01/20 Ending: 12/31/20

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	2.83	7.07%	Alloc. Salary	\$ 20,195	17-7	1
2	Burton Barrish	Relative	Administrative	0.00%	See Attached	3.23	8.08%	Alloc. Salary	8,746	17-7	2
3	Sarah Barrish	Relative	Administrative	0.00%	See Attached	4.04	8.08%	Alloc. Salary	10,383	17-7	3
4	Clark Collins	Relative	Administrative	0.00%	See Attached	3.85	9.63%	Alloc. Salary	5,119	17-7	4
5	Michael Giannini	Relative	Administrative	0.00%	See Attached	3.23	7.18%	Alloc. Salary	14,583	17-7	5
6	Nenita Guzman	Relative	Dietary	0.00%	See Attached	3.23	8.08%	Alloc. Salary	8,386	1-7	6
7	Kirsten Schloss	Relative	Maintenance	0.00%	See Attached	3.23	8.08%	Alloc. Salary	12,594	6-7	7
8	David Winter	Relative	Clerical	0.00%	See Attached	3.23	8.08%	Alloc. Salary	4,183	21-7	8
9	Tom Winter	Relative	Administrative	0.00%	See Attached	3.23	8.08%	Alloc. Salary	20,195	17-7	9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 104,383		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: 01/01/20 Ending: 12/31/20

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: 01/01/20 Ending: 12/31/20

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		Unit of Allocation		Number of	Total Indirect	Amount of Salary		Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units		
1	2	Dietary Other and Rebates	Patient Days	832,144	19	\$ (46,886)	\$	67,219	\$ (3,787)	1
2	6	Repairs & Maintenance	Patient Days	832,144	19	228,292	155,904	67,219	18,441	2
3	7	Emp. Ben. - General Svc.	Patient Days	832,144	19	28,781		67,219	2,325	3
4	9	Medical Director Consults	Patient Days	832,144	19			67,219		4
5	10	Nursing	Patient Days	832,144	19	1,095,433	1,094,370	67,219	88,487	5
6	15	Emp. Ben. - Health Care	Patient Days	832,144	19	204,429		67,219	16,513	6
7	17	Administrative	Patient Days	832,144	19	347,566	347,566	67,219	28,076	7
8	19	Professional Fees	Patient Days	832,144	19	138,762		67,219	11,209	8
9	20	Fee, Subscriptions	Patient Days	832,144	19	49,284		67,219	3,981	9
10	21	Clerical & General	Patient Days	832,144	19	4,236,976	3,850,828	67,219	342,255	10
11	24	Education & Seminar	Patient Days	832,144	19	6,287		67,219	508	11
12	25	Other Admin. Staff Transportatio	Patient Days	832,144	19	112,731		67,219	9,106	12
13	26	Insurance	Patient Days	832,144	19	32,419		67,219	2,619	13
14	27	Emp. Ben. - Gen. Admin.	Patient Days	832,144	19	371,977		67,219	30,048	14
15	32	Interest	Patient Days	832,144	19	(27,854)		67,219	(2,250)	15
16	35	Auto Rental	Patient Days	832,144	19	70,001		67,219	5,655	16
17	35	Equipment Rental	Patient Days	832,144	19	12,377		67,219	1,000	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 6,860,575	\$ 5,448,668		\$ 554,186	25

Facility Name & ID Number Generations at Regency

0049841 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 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	1	Dietary Salaries	Patient Days	832,144	19	\$ 103,820	\$ 103,820	67,219	\$ 8,386	1
2	7	Emp. Ben. - Dietary	Patient Days	832,144	19	19,413		67,219	1,568	2
3	17	Admin./Legal Salaries	Patient Days	832,144	19	2,093,591	2,093,591	67,219	169,116	3
4	19	Fin. Consult./Regl. Dir.	Patient Days	832,144	19	208,920		67,219	16,876	4
5	27	Emp. Ben. - Administrative	Patient Days	832,144	19	485,424		67,219	39,212	5
6										6
7										7
8										8
9										9
10										10
11	6	Maintenance Salaries	Maintenance Income	702,930	17	726,469	726,469	3,930	4,062	11
12	7	Employee Benefits	Maintenance Income	702,930	17	141,032		3,930	788	12
13										13
14	5	Utilities	Allocated Sq. Ft.	12,879	19	27,900		1,040	2,253	14
15	6	Repairs & Maintenance	Allocated Sq. Ft.	12,879	19	24,049		1,040	1,942	15
16	19	Professional Fees	Allocated Sq. Ft.	12,879	19	6,801		1,040	549	16
17	21	Clerical & General	Allocated Sq. Ft.	12,879	19	1,754		1,040	142	17
18	26	Insurance	Allocated Sq. Ft.	12,879	19	3,403		1,040	275	18
19	30	Depreciation	Allocated Sq. Ft.	12,879	19	71,181		1,040	5,748	19
20	32	Interest	Allocated Sq. Ft.	12,879	19	51,631		1,040	4,169	20
21	33	Real Estate Taxes	Allocated Sq. Ft.	12,879	19	123,763		1,040	9,994	21
22										22
23										23
24										24
25	TOTALS					\$ 4,089,151	\$ 2,923,880		\$ 265,080	25

Facility Name & ID Number Generations at Regency # 0049841 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	10	Nursing And Medical Records	Direct Allocation			\$	\$		63,893	1
2	21	Clerical & General Office Expenses	Direct Allocation						570	2
3	22	Employee Benefits	Direct Allocation						5,836	3
4	39	Ancillary	Direct Allocation						380,695	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					\$	\$		450,994	25

Facility Name & ID Number Generations at Regency # 0049841 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	<u>Dietary</u>	<u>Direct Allocation</u>			\$			\$ 8,910	1
	2	<u>Housekeeping</u>	<u>Direct Allocation</u>						56,556	2
	3	<u>Laundry</u>	<u>Direct Allocation</u>						1,864	3
	4	<u>Repairs & Maintenance</u>	<u>Direct Allocation</u>						2,595	4
	5	<u>Nursing And Medical Records</u>	<u>Direct Allocation</u>						291,001	5
	6	<u>Therapy</u>	<u>Direct Allocation</u>						46,483	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				\$	\$		\$ 407,409	25

Facility Name & ID Number Generations at Regency # 0049841 Report Period Beginning: 01/01/20 Ending: 12/31/20

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: 01/01/20 Ending: 12/31/20

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: 01/01/20 Ending: 12/31/20

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: 01/01/20 Ending: 12/31/20

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: 01/01/20 Ending: 12/31/20

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	1st Source Bank		X	Vehicle Note			\$	50,178			\$	4,009	1	
2	VGM Financial		X	Vent Lease			\$	98,774			\$	6,682	2	
3	Cambridge Realty		X	Mortgage			\$	23,088,858			\$	811,110	3	
4							\$				\$		4	
5							\$				\$		5	
	Working Capital													
6	Lake Forest Bank	X		Line of Credit				800,000				60,883	6	
7	Shareholder Loan	X		Related Party Loan				1,400,000					7	
8													8	
9	TOTAL Facility Related						\$	25,437,810				\$	882,684	9
	B. Non-Facility Related*													
10	Interest Income	X										(16,361)	10	
11	Interest Income - Bldg Co.	X										(86)	11	
12	Allocated from GHCN	X										1,919	12	
13													13	
14	TOTAL Non-Facility Related						\$					\$	(14,527)	14
15	TOTALS (line 9+line14)						\$	25,437,810				\$	868,156	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 148,501 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 (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	928,933	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	792,220	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(136,713)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	836,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	20,433	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	720,220	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2015	880,133	8		
		2016	838,648	9		
		2017	888,462	10		
		2018	865,814	11		
		2019	782,226	12		
2020 Accrual = \$796,746 (full amount) x 1.05 = \$836,500 (rounded)						
Line 1 is adjusted by \$9808, which is the amount of real estate tax expense allocated to the training center and other non-care.				13	FROM R. E. TAX STATEMENT FOR 2019 \$	13
				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Generations at Regency COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049841

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 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 2019.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 10-31-401-046-0000	Long Term Property Care	\$ 796,746.36	\$ 782,225.66
2. See Attached	SIR Training	\$ 796,746.36	\$ 781.71
3. See Attached	Allocated from SIR Properties	\$ 148,905.51	\$ 9,416.95
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 1,742,398	\$ 792,424

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 2019 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 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Generations at Regency COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0049841

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE () FAX #: ()

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 X 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).
Office Building including Generations Healthcare Network Training Center

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	\$ 13,150,000	\$ 643,511	39	\$ 337,179	\$ (306,332)	\$ 3,615,747
5										
6										
7										
8										
	Improvement Type**									
9	Various		2008		252,676		20	11,601	11,601	168,663
10	Various		2009		547,020		20	26,925	26,925	323,945
11	Various		2010		392,518		20	19,626	19,626	211,408
12	Various		2011		827,018		20	40,525	40,525	411,515
13	Various		2012		124,944		20	6,246	6,246	54,072
14	Various		2013		276,905		20	13,846	13,846	106,128
15	Various		2014		51,349		20	2,568	2,568	17,400
16	Various		2015		5,763		20	289	289	1,515
17	Various		2016		36,225		20	1,812	1,812	7,501
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

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)		8,448,451			422,172	422,172	4,207,397	67
68	Related Party Allocations (Pages 12H & 12I)		168,300	3,219		5,080	1,862	103,751	68
69	Financial Statement Depreciation			140,670			(140,670)		69
70	TOTAL (lines 4 thru 69)		\$ 24,281,169	\$ 787,400		\$ 887,870	\$ 100,470	\$ 9,229,042	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:

01/01/20

Ending:

12/31/20

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		\$ 24,281,169	\$ 787,400		\$ 887,870	\$ 100,470	\$ 9,229,042	1
2	Removal And Replacement Of Concrete Ramp	2018	11,457		20	573	573	1,432	2
3	Delay Egress	2018	4,870		20	244	244	609	3
4	Walk-In Cooler Door	2018	5,417		20	271	271	610	4
5	Replace Packing On Passenger Elevator	2018	2,950		20	148	148	320	5
6	Elevator Door Controller (2) (Book)	2019	9,735		20	487	487	690	6
7	East Elevator Sill (Book)	2019	4,193		20	210	210	262	7
8	Shower Room Flooring	2019	7,273		20	364	364	425	8
9	2Nd Fl Em Project	2019	11,600		20	580	580	822	9
10	2Nd Fl Dimmers	2019	3,196		20	160	160	173	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)		\$ 24,341,860	\$ 787,400		\$ 890,907	\$ 103,507	\$ 9,234,385	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:

01/01/20

Ending:

12/31/20

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		\$ 24,341,860	\$ 787,400		\$ 890,907	\$ 103,507	\$ 9,234,385	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)		\$ 24,341,860	\$ 787,400		\$ 890,907	\$ 103,507	\$ 9,234,385	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:

01/01/20

Ending:

12/31/20

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		\$ 24,341,860	\$ 787,400		\$ 890,907	\$ 103,507	\$ 9,234,385	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)		\$ 24,341,860	\$ 787,400		\$ 890,907	\$ 103,507	\$ 9,234,385	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:

01/01/20

Ending:

12/31/20

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		\$ 24,341,860	\$ 787,400		\$ 890,907	\$ 103,507	\$ 9,234,385	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)		\$ 24,341,860	\$ 787,400		\$ 890,907	\$ 103,507	\$ 9,234,385	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:

01/01/20

Ending:

12/31/20

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	Various	2009	818,516		20	40,926	40,926	491,112	9
10	Various	2010	518,211		20	25,910	25,910	285,014	10
11	1st Floor Resident Room Work	2011	4,500		20	225	225	2,250	11
12	PT Recovey Room	2011	4,000		20	200	200	2,025	12
13	Dialysis Water Purification	2011	6,385		20	319	319	3,192	13
14	Custom Cabinets	2011	4,000		20	200	200	2,000	14
15	Grocery Cabinets	2011	7,900		20	395	395	3,950	15
16	Outdoor Iron Gates and Fencing	2011	9,245		20	462	462	4,622	16
17	Sump Pump	2011	7,342		20	367	367	3,671	17
18	Landscape Improvements - Trees & Plants	2011	11,340		20	567	567	5,670	18
19	1st Floor Suites - Cabinets & Granite Tops	2011	28,700		20	1,435	1,435	14,350	19
20	Cabinetry	2011	8,600		20	430	430	4,300	20
21	Window Treatment	2011	11,587		20	579	579	5,792	21
22	Window Treatment	2011	19,302		20	965	965	9,651	22
23	Window Treatments	2011	3,003		20	150	150	1,501	23
24	Cubicle Curtains - Dialysis	2011	7,051		20	353	353	3,527	24
25	Install Corner Guards	2011	3,840		20	192	192	1,920	25
26	Kitchen Dishwasher Install	2011	5,306		20	265	265	2,652	26
27	Family Room Wall Prep & Paint	2011	2,700		20	135	135	1,350	27
28	Mason Wall for Garbage Enclosure	2011	6,500		20	325	325	3,250	28
29	Dialysis , Therapy, & Dining Room & 1st Flr & Basement Remode	2011	5,662,788		20	283,139	283,139	2,831,392	29
30	Architect Fee-Dialysis, Therapy&Dining Rooms &1st Floor&Base	2011	479,093		20	23,955	23,955	239,550	30
31	Fees Dialysis, Therapy &Dining Rooms & 1st Flr & Basement Rer	2011	299,630		20	14,982	14,982	149,817	31
32	Contracter Fee - Dialysis, Therapy & Dining Rooms & 1st Flr & B	2011	36,491		20	1,825	1,825	18,247	32
33	Administrative Offices	2009	250,000		20	12,500	12,500	75,000	33
34	TOTAL (lines 1 thru 33)		\$ 8,216,030	\$		\$ 410,801	\$ 410,801	\$ 4,165,805	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:

01/01/20

Ending:

12/31/20

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		\$ 8,216,030	\$		\$ 410,801	\$ 410,801	\$ 4,165,805	1
2	Walk-in Freezer Work	2015	8,484		20	424	424	2,544	2
3	Door to Walk-in Freezer	2015	4,767		20	238	238	1,429	3
4	Wireless Network Upgrade	2015	15,589		20	779	779	4,675	4
5	Custom Elevator Pit Ladder	2015	10,665		20	533	533	3,199	5
6	Parking Lot Re-Stripe	2015	7,400		20	370	370	2,220	6
7	Stairwell Safety Signs	2015	2,591		20	130	130	779	7
8	Thru Wall Air Conditioners	2015	4,207		20	210	210	1,261	8
9	LED Lighting	2016	24,258		20	1213	1,213	6,065	9
10	Outdoor Sign	2016	7,655		20	383	383	1,915	10
11	Privacy Curtains 3rd and 4th floors	2016	2,974		20	149	149	744	11
12	100 Amp Sub Panels - Basements Electrical Room and Linen Closet	2017	11,800		20	590	590	2,360	12
13	Elevator - Control Boards/Selector Replacement	2017	4,184		20	209	209	836	13
14	ATS Switch on Generator Retrofit Power Panel and Controller	2017	9,368		20	468	468	1,872	14
15	Tuckpointing/Lintel/Flashing Repair - Floors 1-4 North Facing Bldg	2017	13,240		20	662	662	2,648	15
16	Freight Elevator - Repair Detector Edge and Control Panel	2017	4,641		20	232	232	928	16
17	Wiring and Circuit Breakers	2018	12,000		20	600	600	1,800	17
18	Elevator #1 Pump Unit	2018	13,790		20	690	690	2,070	18
19	Outdoor Patio Gate Locks	2019	6,500		20	271	271	542	19
20	Elevator Works	2019	4,290		20	179	179	358	20
21	Elevator replace detector edge	2019	2,532		20	74	74	148	21
22	Second floor Plumbing Work	2019	3,200		20	53	53	106	22
23	Elevator Work	2019	3,579		20	179	179	358	23
24	2nd floor call light	2020	25,406		20	1,270	1,270	1,270	24
25	Replace 10 A/C Units	2020	8,394		20	420	420	420	25
26	Generator Repairs	2020	17,582		20	879	879	879	26
27	Sewer Work	2020	3,325		20	166	166	166	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,448,451	\$		\$ 422,172	\$ 422,172	\$ 4,207,397	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:

01/01/20

Ending:

12/31/20

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	40,376	1,078	39	1,035	(42)	11,431	3
4	Allocated from S.I.R. Properties/GHN	1993	36,553	1,160	35	1,044	(116)	27,676	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Generations Healthcare Network, LLC	1993	9,267	258	20		(258)	9,267	9
10	Allocated from Generations Healthcare Network, LLC	1994	29		20			29	10
11	Allocated from Generations Healthcare Network, LLC	1995	212		20			212	11
12	Allocated from Generations Healthcare Network, LLC	1997	14,240	319	20		(319)	14,240	12
13	Allocated from Generations Healthcare Network, LLC	1999	1,120		20	42	42	1,120	13
14	Allocated from Generations Healthcare Network, LLC	1999							14
15	Allocated from Generations Healthcare Network, LLC	2000	1,322		20	30	30	1,322	15
16	Allocated from Generations Healthcare Network, LLC	2007	4,248		20	212	212	2,802	16
17	Allocated from Generations Healthcare Network, LLC	2008	11,706		20	433	433	8,562	17
18	Allocated from Generations Healthcare Network, LLC	2009	29,087		20	1,454	1,454	16,354	18
19	Allocated from Generations Healthcare Network, LLC	2011	720	72	20	72		678	19
20	Allocated from Generations Healthcare Network, LLC	2012	2,303	115	20	115		854	20
21	Allocated from Generations Healthcare Network, LLC	2014	323	32	20	16	(16)	106	21
22	Allocated from Generations Healthcare Network, LLC	2016	420	21	20	21		93	22
23	Allocated from Generations Healthcare Network, LLC	2019	2,095	103	20	103		131	23
24	Allocated from Generations Healthcare Network, LLC	2020	1,707	36	20	36	0	36	24
25									25
26	Allocated from S.I.R. Properties/GHN	2012	2,239		20	112	112	784	26
27	Allocated from S.I.R. Properties/GHN	2010	2,206		20	110	110	1,029	27
28	Allocated from S.I.R. Properties/GHN	2009	2,195		20	110	110	1,185	28
29	Allocated from S.I.R. Properties/GHN	2007	216	13	20	11	(2)	141	29
30	Allocated from S.I.R. Properties/GHN	2002	145		20	7	7	127	30
31	Allocated from S.I.R. Properties/GHN	1999	4,632		20	116	116	4,632	31
32	Allocated from S.I.R. Properties/GHN	1994	348	9	20		(9)	348	32
33	Allocated from S.I.R. Properties/GHN	1993	593	3	20		(3)	593	33
34	TOTAL (lines 1 thru 33)		\$ 168,300	\$ 3,219		\$ 5,080	\$ 1,862	\$ 103,751	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:

01/01/20

Ending:

12/31/20

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		\$ 168,300	\$ 3,219		\$ 5,080	\$ 1,862	\$ 103,751	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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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)		\$ 168,300	\$ 3,219		\$ 5,080	\$ 1,862	\$ 103,751	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	\$ 1,620,347	\$ 1,712	\$ 160,005	\$ 158,293	10	\$ 1,454,700	71
72	Current Year Purchases	5,555	23	544	522	10	544	72
73	Fully Depreciated Assets	249,985				10	249,985	73
74								74
75	TOTALS	\$ 1,875,887	\$ 1,735	\$ 160,549	\$ 158,814		\$ 1,705,228	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	\$	\$ 9,380	\$ 9,380	5	\$ 29,638	76
77		2019 Ford Transit	2019	55,600		11,120	11,120	5	13,900	77
78										78
79		See Attached		9,522	794	1,438	644		5,102	79
80	TOTALS			\$ 112,023	\$ 794	\$ 21,938	\$ 21,144		\$ 48,640	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)	\$ 27,204,769	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 789,929	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,073,394	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 283,465	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 10,988,253	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	\$	\$	86
87	Land- Vacant Parcel - 2009	400,000			87
88	Land- Office Buidling - 2009	225,000			88
89	Tuckpointing/Linel/Flashing - 2017	6,620			89
90					90
91	TOTALS	\$ 1,381,620	\$	\$	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?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$4,114
- Description: See Attached

(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	Alloc. GHCN		\$	\$5,655	17
18					18
19					19
20					20
21	TOTAL		\$	\$5,655	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.	/2021	\$
13.	/2022	\$
14.	/2023	\$

* 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)	\$			

- (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.

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	

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

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs	\$			\$ 613,205	\$		\$ 613,205	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				134,240			134,240	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39 - 03	hrs				647,017			647,017	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					411,745		411,745	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify):				367,076		428,073	16,107		811,256	13
14	TOTAL			\$ 367,076		\$ 1,822,535	\$ 427,852		\$ 2,617,463	14	

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,394,252	\$ 1,664,929	1
2	Cash-Patient Deposits	126,613	126,613	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,113,331	4,113,331	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	93,856	208,135	6
7	Other Prepaid Expenses	46,149	46,149	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	489,075	1,192,951	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,263,276	\$ 7,352,108	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		19,855,805	14
15	Leasehold Improvements, at Historical Cost	2,325,729	4,081,484	15
16	Equipment, at Historical Cost	811,356	1,987,709	16
17	Accumulated Depreciation (book methods)	(1,584,326)	(8,768,569)	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):	88,353	8,630,069	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,641,112	\$ 27,286,498	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,904,388	\$ 34,638,606	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,220,010	\$ 2,220,010	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	126,607	126,607	28
29	Short-Term Notes Payable	2,348,952	2,348,952	29
30	Accrued Salaries Payable	569,268	569,268	30
31	Accrued Taxes Payable (excluding real estate taxes)	387,120	387,120	31
32	Accrued Real Estate Taxes(Sch.IX-B)		836,500	32
33	Accrued Interest Payable		68,305	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		3,260,303	3,350,656	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 8,912,260	\$ 9,907,418	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		23,088,858	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43			2,510,000	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 25,598,858	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,912,260	\$ 35,506,276	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,007,872)	\$ (867,670)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,904,388	\$ 34,638,606	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,408,590)	1
2	Restatements (describe):		2
3	Rounding	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,408,588)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	400,716	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)	\$ 400,716	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)	\$ (1,007,872)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Generations at Regency

0049841

Report Period Beginning:

01/01/20

Ending:

12/31/20

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	\$ 16,692,089	1
2	Discounts and Allowances for all Levels	(2,772,318)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,919,771	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,217,610	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,217,610	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	393,898	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	82,961	19
20	Radiology and X-Ray	14,281	20
21	Other Medical Services	107,747	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 598,887	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	16,361	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 16,361	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	2,349,672	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,349,672	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 21,102,301	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,693,182	31
32	Health Care	7,998,311	32
33	General Administration	3,957,978	33
	B. Capital Expense		
34	Ownership	2,905,660	34
	C. Ancillary Expense		
35	Special Cost Centers	2,622,507	35
36	Provider Participation Fee	523,947	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 20,701,585	40
41	Income before Income Taxes (line 30 minus line 40)**	400,716	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 400,716	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,838,097	44
45	Private Pay - Net Inpatient Revenue	1,454,981	45
46	Medicare - Net Inpatient Revenue	2,135,560	46
47	Other-(specify) <u>Managed Care / Insurance</u>	7,270,497	47
48	Other-(specify) <u>Hospice</u>	220,636	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 13,919,771	49

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

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

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

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

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,809	2,071	\$ 138,788	\$ 67.01	1
2	Assistant Director of Nursing	4,584	5,195	208,023	40.04	2
3	Registered Nurses	40,314	44,460	1,473,470	33.14	3
4	Licensed Practical Nurses	41,653	44,804	1,365,168	30.47	4
5	CNAs & Orderlies	93,241	101,713	1,740,452	17.11	5
6	CNA Trainees					6
7	Licensed Therapist	10,007	10,646	367,076	34.48	7
8	Rehab/Therapy Aides	7,752	8,880	188,518	21.23	8
9	Activity Director					9
10	Activity Assistants	11,889	13,343	193,631	14.51	10
11	Social Service Workers	8,707	9,708	224,297	23.10	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	37,804	41,758	618,779	14.82	15
16	Dishwashers					16
17	Maintenance Workers	6,699	7,432	181,132	24.37	17
18	Housekeepers	27,656	30,196	422,292	13.99	18
19	Laundry	3,735	4,054	54,608	13.47	19
20	Administrator	1,930	2,091	133,971	64.07	20
21	Assistant Administrator	3,830	3,951	112,427	28.46	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,099	3,477	64,071	18.43	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	7,462	8,009	254,068	31.72	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	2,599	2,907	82,483	28.37	33
34	TOTAL (lines 1 - 33)	314,770	344,695	\$ 7,823,254 *	\$ 22.70	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	\$ 76,494	01-03	35
36	Medical Director	Monthly	39,000	09-03	36
37	Medical Records Consultant	Monthly	4,400	10-03	37
38	Nurse Consultant	Monthly	104,160	10-03	38
39	Pharmacist Consultant	Monthly	14,323	10-03	39
40	Physical Therapy Consultant	315	15,773	10a-03	40
41	Occupational Therapy Consultant	322	16,003	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	151	7,259	10a-03	43
44	Activity Consultant	Monthly	5,096	11-03	44
45	Social Service Consultant	Monthly	1,680	12-03	45
46	Other(specify)				46
47	Psychiatric	Monthly	2,000	12-03	47
48	Restorative Nursing Consultant	Per Visit	26	10-03	48
49	TOTAL (lines 35 - 48)	788	\$ 286,214		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,352	\$ 147,966	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	40,765	1,264,712	10-03	52
53	TOTAL (lines 50 - 52)	43,117	\$ 1,412,678		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Joseph Jaiver	Administrator		\$ 133,971
Suddy S Salgado	Asst. Administrator		83,671
Pravin Waranimman	Asst. Administrator		28,756
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 246,398
B. Administrative - Other			
Description			Amount
GHN - Dir. of Administrative Services		\$	117,600
GHN - Ancillary Administrative Charges			84,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		\$	201,600
C. Professional Services			
Vendor/Payee	Type		Amount
Generations Healthcare Network	Dir. of Financial Services	\$	90,720
Generations Healthcare Network	Dir. of Business Development		238,560
Generations Healthcare Network	Dir. of Regulatory Services		33,600
Generations Healthcare Network	Dir. of Information Technology		20,160
Generations Healthcare Network	Bookkeeping Services		373,800
Generations Healthcare Network	Computer Support Charges		73,920
Personnel Planners	Unemployment Tax Consultant		1,455
Marcum LLP	Accounting Fees		16,200
Plante & Moran	Accounting Fees		4,940
On Shift Inc	Data Processing		2,903
See Attached	Legal		29,310
See Supplemental Schedule			111,076
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$	996,644
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	143,766
Unemployment Compensation Insurance			14,992
FICA Taxes			598,479
Employee Health Insurance			693,257
Employee Meals			31,952
Illinois Municipal Retirement Fund (IMRF)*			
401K Matching Contr.			10,450
Employee Benefits - Other			27,954
TOTAL (agree to Schedule V, line 22, col.8)		\$	1,520,850
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		\$	1,992
Advertising: Employee Recruitment			23,095
Health Care Worker Background Check (Indicate # of checks performed 275)			2,745
Patient Background Checks 49			493
Dues & Subscriptions			16,640
Licenses & Fees			3,886
See Supplemental Schedule			3,981
Less: Public Relations Expense ()			
Non-allowable advertising ()			
Yellow page advertising ()			
TOTAL (agree to Sch. V, line 20, col. 8)		\$	52,832
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
Seminar Expense			781
See Supplemental Schedule			508
Entertainment Expense ()			
TOTAL (agree to Sch. V, line 24, col. 8)		\$	1,289

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name & ID Number Generations at Regency	STATE OF ILLINOIS # 0049841	Report Period Beginning: 01/01/20	Ending: 12/31/20
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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?
If YES, give association name and amount. HCCI - \$21,000

(3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period? Yes
10 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 52,943 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? 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. \$ 523,947
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 31,952 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? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.