FOR BHF USE

LL1

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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0054239

Facility Name: Decatur Manor Healthcare

Address: 1016 W. Pershing Rd. (Number) Decatur (City) 62526 (Zip Code)

County: Macon

Telephone Number: (217) 875-0833 **Fax #** (217) 875-6851

HFS ID Number:

Date of Initial License for Current Owners: 10/1/2005

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/17 to 12/31/17 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	147	Intermediate (ICF)	147	53,655	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	147	TOTALS	147	53,655	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	41,788	398	5,491	47,677	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,788	398	5,491	47,677	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.86%

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 [ ] NO [X]

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 [ ] NO [X] If YES, enter number of beds certified ____ and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Decatur Manor Healthcare # 0054239 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	178,527	26,811	29,921	235,259		235,259	(11,441)	223,818			1
2	Food Purchase		271,596		271,596	(6,753)	264,844	(2,252)	262,592			2
3	Housekeeping	145,045	33,522		178,567		178,567	(2,654)	175,913			3
4	Laundry	35,991	7,633		43,624		43,624	(9)	43,615			4
5	Heat and Other Utilities			119,455	119,455		119,455	(11,362)	108,093			5
6	Maintenance	59,551	17,750	105,518	182,819		182,819	(12,846)	169,973			6
7	Other (specify):*							3,796	3,796			7
8	**TOTAL General Services**	419,114	357,312	254,894	1,031,320	(6,753)	1,024,568	(36,768)	987,799			8
	B. Health Care and Programs											
9	Medical Director							5,633	5,633			9
10	Nursing and Medical Records	996,227	58,357	56,447	1,111,031		1,111,031	(21,259)	1,089,772			10
10a	Therapy			25,140	25,140		25,140	(11,442)	13,698			10a
11	Activities	66,977	15,370	1,100	83,447		83,447		83,447			11
12	Social Services	178,661		48,000	226,661		226,661		226,661			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							8,708	8,708			15
16	**TOTAL Health Care and Programs**	1,241,865	73,727	130,687	1,446,279		1,446,279	(18,360)	1,427,919			16
	C. General Administration											
17	Administrative	129,051		329,118	458,169		458,169	(208,179)	249,990			17
18	Directors Fees											18
19	Professional Services			232,852	232,852		232,852	(155,973)	76,880			19
20	Dues, Fees, Subscriptions & Promotions			66,072	66,072		66,072	(32,525)	33,547			20
21	Clerical & General Office Expenses	103,966	34,785	61,359	200,110		200,110	84,884	284,994			21
22	Employee Benefits & Payroll Taxes			248,185	248,185	6,753	254,938		254,938			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,726	5,726		5,726	158	5,884			24
25	Other Admin. Staff Transportation			12,817	12,817		12,817	9,629	22,446			25
26	Insurance-Prop.Liab.Malpractice			105,153	105,153		105,153	1,791	106,944			26
27	Other (specify):*							36,599	36,599			27
28	**TOTAL General Administration**	233,017	34,785	1,061,282	1,329,084	6,753	1,335,837	(263,615)	1,072,221			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,893,996	465,824	1,446,863	3,806,683		3,806,683	(318,743)	3,487,940			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.

Facility Name & ID Number Decatur Manor Healthcare #0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			54,553	54,553		54,553	224,609	279,162			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,978	32,978		32,978	150,346	183,324			32
33	Real Estate Taxes							63,688	63,688			33
34	Rent-Facility & Grounds			408,000	408,000		408,000	(408,000)				34
35	Rent-Equipment & Vehicles			3,785	3,785		3,785	4,343	8,128			35
36	Other (specify):*											36
37	**TOTAL Ownership**			499,316	499,316		499,316	34,986	534,302			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**											44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,893,996	465,824	1,946,179	4,305,999		4,305,999	(283,757)	4,022,242			45

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

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	(13,132)	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	16,846	30		9
10	Interest and Other Investment Income	(55,410)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(23)	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	(14,020)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(19,703)	21		24
25	Fund Raising, Advertising and Promotional	(10,796)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,561)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(49,157)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (151,956)		$	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)	(131,802)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (131,802)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (283,758)		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

Decatur Manor Healthcare

ID# 0054239

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Veterans Prescription Drugs	$ (23,451)	10	1
2	Bank Fees	(8,020)	21	2
3	Theft & Damage Loss	(273)	21	3
4	Vending Income	(2,229)	02	4
5	Miscellaneous Income	(65)	21	5
6	Additional R&M	1,605	06	6
7	Capitalized R&M	(5,334)	06	7
8	PAC Dues	(7,970)	20	8
9	Non-allowable Legal	(1,462)	19	9
10	Building Co. - Filing Fees	(250)	21	10
11	Building Co. - Office Expenses	(58)	21	11
12	Building Co. - Amortization	(1,650)	36	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(49,157)		49

Decatur Manor Healthcare

ID# 0054239

Report Period Beginning: 01/01/17

Ending: 12/31/17

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Decatur Manor Healthcare # 0054239 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary				(11,147)	(294)							(11,441)	1
2	Food Purchase	(2,252)											(2,252)	2
3	Housekeeping					(2,654)							(2,654)	3
4	Laundry					(9)							(9)	4
5	Heat and Other Utilities	(13,132)			1,770								(11,362)	5
6	Maintenance	(3,729)		(9,404)	1,314	(1,027)							(12,846)	6
7	Other (specify):*			1,142	2,654								3,796	7
8	**TOTAL General Services**	(19,113)		(8,262)	(5,409)	(3,984)							(36,768)	8
	B. Health Care and Programs													
9	Medical Director			5,633									5,633	9
10	Nursing and Medical Records	(23,451)		(2,729)	7,381	(2,460)							(21,259)	10
10a	Therapy				(11,442)								(11,442)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			5,048	3,660								8,708	15
16	**TOTAL Health Care and Programs**	(23,451)		7,952	(401)	(2,460)							(18,360)	16
	C. General Administration													
17	Administrative			(305,820)	97,641								(208,179)	17
18	Directors Fees													18
19	Professional Services	(1,462)		(168,329)	13,818								(155,973)	19
20	Fees, Subscriptions & Promotions	(32,786)		261									(32,525)	20
21	Clerical & General Office Expenses	(34,930)	308	119,392	142	(28)							84,884	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			158									158	24
25	Other Admin. Staff Transportation			9,629									9,629	25
26	Insurance-Prop.Liab.Malpractice			1,607	184								1,791	26
27	Other (specify):*			12,548	24,051								36,599	27
28	**TOTAL General Administration**	(69,178)	308	(330,554)	135,836	(28)							(263,615)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(111,742)	308	(330,864)	130,026	(6,472)							(318,743)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Decatur Manor Healthcare # 0054239 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	16,846	201,516		6,247								224,609	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(55,410)	204,454	(3,905)	5,207								150,346	32
33	Real Estate Taxes		55,906		7,782								63,688	33
34	Rent-Facility & Grounds		(408,000)										(408,000)	34
35	Rent-Equipment & Vehicles			4,343									4,343	35
36	Other (specify):*	(1,650)	1,650											36
37	TOTAL Ownership	(40,214)	55,526	438	19,236								34,986	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(151,956)	55,834	(330,426)	149,262	(6,472)							(283,757)	45

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 408,000	Decatur Healthcare Estates	100.00%	$	$ (408,000)	1
2	V	21	Filling Fees		Decatur Healthcare Estates	100.00%	250	250	2
3	V	32	Interest Expense		Decatur Healthcare Estates	100.00%	204,505	204,505	3
4	V	21	Office		Decatur Healthcare Estates	100.00%	58	58	4
5	V	33	Real Estate Taxes		Decatur Healthcare Estates	100.00%	55,600	55,600	5
6	V	33	Real Estate Taxes - Prior		Decatur Healthcare Estates	100.00%	306	306	6
7	V	32	Interest Income	51	Decatur Healthcare Estates	100.00%		(51)	7
8	V	36	Amortization - Loan Fees		Decatur Healthcare Estates	100.00%	1,650	1,650	8
9	V	30	Depreciation		Decatur Healthcare Estates	100.00%	201,516	201,516	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 408,051			$ 463,885	$ * 55,834	14

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

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS AND MAINT.	$ 21,612	GENERATIONS HC NETWORK, LLC	100.00%	$ 12,208	$ (9,404)	15
16	V	7	EMP. BEN.-GEN. SERV.		GENERATIONS HC NETWORK, LLC	100.00%	1,142	1,142	16
17	V	9	MEDICAL DIRECTOR CONSULTS		GENERATIONS HC NETWORK, LLC	100.00%	5,633	5,633	17
18	V	10	NURSING	43,224	GENERATIONS HC NETWORK, LLC	100.00%	40,495	(2,729)	18
19	V	15	EMP. BEN.-H.C.		GENERATIONS HC NETWORK, LLC	100.00%	5,048	5,048	19
20	V	17	ADMINISTRATIVE	329,118	GENERATIONS HC NETWORK, LLC	100.00%	23,298	(305,820)	20
21	V	19	PROFESSIONAL FEES	169,800	GENERATIONS HC NETWORK, LLC	100.00%	1,471	(168,329)	21
22	V	20	FEES,SUBSCRIPTIONS		GENERATIONS HC NETWORK, LLC	100.00%	261	261	22
23	V	21	CLERICAL & GENERAL	7,236	GENERATIONS HC NETWORK, LLC	100.00%	126,628	119,392	23
24	V	24	EDUCATION & SEMINAR		GENERATIONS HC NETWORK, LLC	100.00%	158	158	24
25	V	25	OTHER ADMIN. STAFF TRANS.		GENERATIONS HC NETWORK, LLC	100.00%	9,629	9,629	25
26	V	26	INSURANCE		GENERATIONS HC NETWORK, LLC	100.00%	1,607	1,607	26
27	V	27	EMP. BEN.-GEN. ADMIN.		GENERATIONS HC NETWORK, LLC	100.00%	12,548	12,548	27
28	V	32	INTEREST		GENERATIONS HC NETWORK, LLC	100.00%	(3,905)	(3,905)	28
29	V	35	AUTO RENTAL		GENERATIONS HC NETWORK, LLC	100.00%	3,561	3,561	29
30	V	35	EQUIPMENT RENTAL		GENERATIONS HC NETWORK, LLC	100.00%	782	782	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			$ 570,990			$ 240,564	$ * (330,426)	39

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

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 17,988	GENERATIONS HC NETWORK, LLC	100.00%	$ 6,841	$ (11,147)	15
16	V	7	EMP. BEN.-DIETARY		GENERATIONS HC NETWORK, LLC	100.00%	1,185	1,185	16
17	V	10	NURSING SALARIES		GENERATIONS HC NETWORK, LLC	100.00%	7,381	7,381	17
18	V	15	EMP. BEN.-NURSING		GENERATIONS HC NETWORK, LLC	100.00%	1,274	1,274	18
19	V	17	ADMIN./LEGAL SALARIES		GENERATIONS HC NETWORK, LLC	100.00%	97,641	97,641	19
20	V	19	FIN. CONSULT./REGL. DIR.		GENERATIONS HC NETWORK, LLC	100.00%	13,740	13,740	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		GENERATIONS HC NETWORK, LLC	100.00%	24,051	24,051	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	25,140	GENERATIONS HC NETWORK, LLC	100.00%	13,698	(11,442)	24
25	V	15	EMPLOYEE BENFITS		GENERATIONS HC NETWORK, LLC	100.00%	2,386	2,386	25
26	V								26
27	V	6	MAINTENANCE SALARIES	7,884	GENERATIONS HC NETWORK, LLC	100.00%	8,089	205	27
28	V	7	EMPLOYEE BENEFITS		GENERATIONS HC NETWORK, LLC	100.00%	1,469	1,469	28
29	V								29
30	V	5	UTILITIES		GENERATIONS HC NETWORK, LLC	100.00%	1,770	1,770	30
31	V	6	REPAIRS AND MAINT.		GENERATIONS HC NETWORK, LLC	100.00%	1,109	1,109	31
32	V	19	PROFESSIONAL FEES		GENERATIONS HC NETWORK, LLC	100.00%	78	78	32
33	V	21	CLERICAL & GENERAL		GENERATIONS HC NETWORK, LLC	100.00%	142	142	33
34	V	26	INSURANCE		GENERATIONS HC NETWORK, LLC	100.00%	184	184	34
35	V	30	DEPRECIATION		GENERATIONS HC NETWORK, LLC	100.00%	6,247	6,247	35
36	V	32	INTEREST		GENERATIONS HC NETWORK, LLC	100.00%	5,207	5,207	36
37	V	33	REAL ESTATE TAXES		GENERATIONS HC NETWORK, LLC	100.00%	7,782	7,782	37
38	V								38
39	Total			$ 51,012			$ 200,274	$ * 149,262	39

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

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$ 3,396	Big Ten Supply, LLC	100.00%	$ 3,101	$ (294)	15
16	V	3	Housekeeping	30,615	Big Ten Supply, LLC	100.00%	27,961	(2,654)	16
17	V	4	Laundry	100	Big Ten Supply, LLC	100.00%	92	(9)	17
18	V	6	Repairs & Maintenance	11,852	Big Ten Supply, LLC	100.00%	10,825	(1,027)	18
19	V	10	Nursing And Medical Records	28,379	Big Ten Supply, LLC	100.00%	25,919	(2,460)	19
20	V	10A	Therapy		Big Ten Supply, LLC	100.00%			20
21	V	21	Clerical & General	324	Big Ten Supply, LLC	100.00%	296	(28)	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			$ 74,667			$ 68,195	$ * (6,472)	39

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

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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 Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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 Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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 Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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 Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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 Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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 Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

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, LLC	26.39%	ALBANY CARE INC	EVANSTON	6631 MILWAUKEE, LLC	LINCOLNWOOD	BUILDING CO.	1
2	BARRISH GROUP LIMITED	8.80%	GENERATIONS AT APPLEWOOD, LLC	MATTESON	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	2
3	BRYAN BARRISH TRUST	8.80%	BRYN MAWR CARE INC.	CHICAGO	OAKTON ARMS	DES PLAINES	ASSISTED LIVING	3
4	FAY CHIN	1.34%	GENERATIONS AT COLUMBUS PARK, INC	CHICAGO	MAC Rx LLC	DES PLAINES	PHARMACY	4
5	JEFF ORAVEC	1.34%	GENERATIONS AT REGENCY, LLC	NILES	GENERATIONS HEALTH NETW	LINCOLNWOOD	CONSULTING CO.	5
6	LOUISE BERGTHOLD	3.36%	GENERATIONS AT ELMWOOD PARK, INC	ELMWOOD PARK	BIG TEN SUPPLY, LLC	LIBERTYVILLE	SUPPLY CO.	6
7	LYNN ETHELL	1.34%	GREENWOOD CARE, INC.	EVANSTON				7
8	NENITA GUZMAN	1.34%	GENERATIONS AT NEIGHBORS, LLC	BYRON				8
9	PATRICIA MCDIARMID	1.34%	GENERATIONS AT ROCK ISLAND, LLC	ROCK ISLAND				9
10	RALPH GESUALDO	8.80%	WILSON CARE, INC.	CHICAGO				10
11	RALPH GESUALDO CHILDREN'S TRUST	8.80%	AUBURN VILLAGE	AUBURN, IN				11
12	RONALD NUNZIATO JR.	2.68%	GENERATIONS AT OAKTON, LLC	DES PLAINES				12
13	THOMAS & STEPHANIE WINTER REV. TRUST	6.71%						13
14	UNITED TRUST #1	4.40%						14
15	UNITED TRUST #2	4.40%						15
16	L.G. TRUST	4.39%						16
17	B.G. TRUST	4.39%						17
18	KIM SHELTON	1.34%						18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

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

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bryan Barrish	Relative	Administrative		See Attached	2.4	6.00%	Alloc. Salary	$ 13,740	17-7	1
2	Sarah Barrish	Relative	Administrative		See Attached	3.44	6.88%	Alloc. Salary	8,573	17-7	2
3	Louise Bergthold	Shareholder	Administrative	3.36%	See Attached	4.12	6.87%	Alloc. Salary	13,740	17-7	3
4	Thomas Bergthold	Relative	Clerical		See Attached	2.75	6.88%	Alloc. Salary	2,864	21-7	4
5	Andrew Chin	Relative	Clerical		See Attached	2.75	6.88%	Alloc. Salary	5,536	21-7	5
6	Fay Chin	Shareholder	Nursing	1.34%	See Attached	2.75	6.88%	Alloc. Salary	7,381	10-7	6
7	Clark Collins	Relative	Administrative		See Attached	1.29	3.23%	Alloc. Salary	1,617	Var.	7
8	Lynn Ethell	Shareholder	Clerical	1.34%	See Attached	2.06	6.87%	Alloc. Salary	3,399	21-7	8
9	Mike Giannini	Relative	Administrative		See Attached	2.4	6.00%	Alloc. Salary	11,679	17-7	9
10	Nenita Guzman	Shareholder	Dietary	1.34%	See Attached	3.44	6.88%	Alloc. Salary	6,841	1-7	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.								44,201	PG 7-SUPP	12
13								TOTAL	$ 119,571		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 Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 [X]

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 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
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 Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 [X] 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	6	REPAIRS AND MAINT.	PATIENT DAYS	693,985	14	$ 177,702	$ 95,737	47,677	$ 12,208	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	693,985	14	16,617		47,677	1,142	2
3	9	MEDICAL DIRECTOR CONSUL	PATIENT DAYS	693,985	14	82,000		47,677	5,633	3
4	10	NURSING	PATIENT DAYS	693,985	14	589,441	589,441	47,677	40,495	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	693,985	14	73,484		47,677	5,048	5
6	17	ADMINISTRATIVE	PATIENT DAYS	693,985	14	339,126	339,126	47,677	23,298	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	693,985	14	21,409		47,677	1,471	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	693,985	14	3,801		47,677	261	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	693,985	14	1,843,191	1,656,700	47,677	126,628	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	693,985	14	2,295		47,677	158	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	693,985	14	140,164		47,677	9,629	11
12	26	INSURANCE	PATIENT DAYS	693,985	14	23,394		47,677	1,607	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	693,985	14	182,645		47,677	12,548	13
14	32	INTEREST	PATIENT DAYS	693,985	14	(56,845)		47,677	(3,905)	14
15	35	AUTO RENTAL	PATIENT DAYS	693,985	14	51,827		47,677	3,561	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	693,985	14	11,377		47,677	782	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,501,628	$ 2,681,003		$ 240,564	25

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 [X] 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	693,985	14	$ 99,579	$ 99,579	47,677	$ 6,841	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	693,985	14	17,250		47,677	1,185	2
3	10	NURSING SALARIES	PATIENT DAYS	693,985	14	107,435	107,435	47,677	7,381	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	693,985	14	18,544		47,677	1,274	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	693,985	14	1,421,258	1,421,258	47,677	97,641	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	693,985	14	200,000		47,677	13,740	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	693,985	14	350,079		47,677	24,051	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	329,142	13	179,343	179,343	25,140	13,698	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	329,142	13	31,236		25,140	2,386	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	366,497	14	376,026	376,026	7,884	8,089	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	366,497	14	68,296		7,884	1,469	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,877	14	25,758		885	1,770	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,877	14	16,130		885	1,109	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,877	14	1,139		885	78	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,877	14	2,063		885	142	19
20	26	INSURANCE	ALLOCATED SQ FT	12,877	14	2,682		885	184	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,877	14	90,892		885	6,247	21
22	32	INTEREST	ALLOCATED SQ FT	12,877	14	75,767		885	5,207	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,877	14	113,223		885	7,782	23
24										24
25	TOTALS					$ 3,196,700	$ 2,183,641		$ 200,274	25

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 [X] 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	1	Dietary	Direct Allocation			$	$		$ 3,101	1
2	3	Housekeeping	Direct Allocation						27,961	2
3	4	Laundry	Direct Allocation						92	3
4	6	Repairs & Maintenance	Direct Allocation						10,825	4
5	10	Nursing And Medical Records	Direct Allocation						25,919	5
6	10A	Therapy	Direct Allocation							6
7	21	Clerical & General	Direct Allocation						296	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					$	$		$ 68,195	25

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 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
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 Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 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
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 Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 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
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 Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 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
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 Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 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
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 Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 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
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
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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 Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Centure Bank		X	Mortgage			$	$ 4,176,575			$ 204,505	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Lake Forest Bank & Trust		X	Line of Credit							32,978	6
7												7
8												8
9	TOTAL Facility Related						$	$ 4,176,575			$ 237,483	9
	B. Non-Facility Related*											
10	Interest Income		X								(55,410)	10
11	Interest Income - Bldg Co		X								(51)	11
12	Allocated from Generations Hea	X									5,207	12
13	See Supplemental Schedule										(3,905)	13
14	TOTAL Non-Facility Related						$	$			$ (54,159)	14
15	TOTALS (line 9+line14)						$	$ 4,176,575			$ 183,324	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

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

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

Facility Name & ID Number Decatur Manor Healthcare # 0054239 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	52,900	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.)	$	60,988	2
3. Under or (over) accrual (line 2 minus line 1).	$	8,088	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	55,600	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.)	$		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.	$	63,688	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	46,308	8
	2013	46,700	9
	2014	47,598	10
	2015	50,791	11
	2016	53,206	12

2017 Accrual = $53,206 x 1.04 = 55,600

Allocated from Generations Healthcare Network: $7,782

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Decatur Manor Healthcare COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0054239

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-07-34-351-013	Long Term Care Property	$ 53,206.36	$ 53,206.36
2.	10-31-401-046-0000	Allocated by Regency Property	$ 848,962.66	$ 354.46
3.	See Attached	Allocated by S.I.R. Properties	$ 131,016.59	$ 7,051.85
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,033,185.61	$ 60,612.67

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

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

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Decatur Manor Healthcare COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0054239

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,860 B. General Construction Type: Exterior Masonry Frame Metal Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	130,680	2008	$ 100,000	1
2					2
3	TOTALS	130,680		$ 100,000	3

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	147		2008	1976	$ 2,902,875	$ 46,240	35	$ 82,939	$ 36,699	$ 817,782	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2008	11,477		20	1,148	1,148	11,034	9
10	Various			2009	26,920		20	1,346	1,346	11,368	10
11	Various			2010	26,169		20	1,508	1,508	16,954	11
12	Various			2011	83,931		20	4,475	4,475	28,033	12
13	Various			2012	253,113		20	12,655	12,655	71,113	13
14	Various			2013	36,564		20	1,828	1,828	8,290	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

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)		749,210	68,530		37,772	(30,758)	371,660	67
68	Related Party Allocations (Pages 12H & 12I)		122,821	3,738		4,369	631	73,261	68
69	Financial Statement Depreciation			54,553			(54,553)		69
70	TOTAL (lines 4 thru 69)		$ 4,213,080	$ 173,061		$ 148,040	$ (25,021)	$ 1,409,495	70

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

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 4,213,080	$ 173,061		$ 148,040	$ (25,021)	$ 1,409,495	1
2	Rebuilt Tempering Valve	2014	6,174		20	309	309	1,003	2
3	Concrete Pad (Patio) And Driveway	2014	14,300		20	715	715	2,324	3
4	Freezer	2014	6,482		20	648	648	2,107	4
5	Paintingprep 71 Rms / 12 Rms B Hall / 1 Rm F Hall	2014	5,650		20	283	283	1,106	5
6	24 Interior Rooms Painted	2014	10,000		20	500	500	1,708	6
7	Electrical Repairs, Lighting Replaced In Laundry Room, Kitchen,	2014	8,083		20	404	404	1,516	7
8	A&B Wing Painting	2014	3,600		20	180	180	555	8
9	Hot Water Heater	2015	5,325		20	266	266	799	9
10	Roof Work (West)	2015	10,350		20	518	518	1,380	10
11	Hot Water Heater	2015	10,956		20	548	548	1,278	11
12	Laminate Flooring (4 Rooms)	2015	6,590		20	330	330	741	12
13	Wireless Network	2015	6,988		20	349	349	815	13
14	1 Hp Sump Pump	2016	6,865		20	343	343	658	14
15	Storage Shed With Concrete Pad	2016	10,006		20	500	500	876	15
16	Furnace	2016	4,226		20	211	211	247	16
17	Wiring Magnet Front Door	2016	3,075		20	154	154	282	17
18	Furnace For Ewing	2017	5,265		20	241	241	241	18
19	Front Door Alarm	2017	4,064		20	135	135	135	19
20	Furnace For Gwing	2017	5,699		20	24	24	24	20
21	Hvac Repairs	2017	2,522		20	126	126	126	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)		$ 4,349,300	$ 173,061		$ 154,824	$ (18,237)	$ 1,427,416	34

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

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 4,349,300	$ 173,061		$ 154,824	$ (18,237)	$ 1,427,416	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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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)		$ 4,349,300	$ 173,061		$ 154,824	$ (18,237)	$ 1,427,416	34

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

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 4,349,300	$ 173,061		$ 154,824	$ (18,237)	$ 1,427,416	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,349,300	$ 173,061		$ 154,824	$ (18,237)	$ 1,427,416	34

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

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 4,349,300	$ 173,061		$ 154,824	$ (18,237)	$ 1,427,416	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		$ 4,349,300	$ 173,061		$ 154,824	$ (18,237)	$ 1,427,416	34

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

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Roof	2008	83,141		20	4,157	4,157	41,570	9
10	Hand Rails	2008	41,519		20	2,076	2,076	20,760	10
11	Demolition, Framing,Plumbing, Heating…	2008	71,200		20	3,560	3,560	35,600	11
12	Demolition, Electical,Plumbing, Painting,Flooring….	2008	455,946		20	22,797	22,797	227,970	12
13	Painting Doors	2008	7,840		20	392	392	3,920	13
14	Draperies	2008	35,206		20	1,760	1,760	17,600	14
15	Trane A/C Unit	2010	12,989		20	649	649	5,192	15
16	Fire Alarm	2010	7,539		20	377	377	3,016	16
17	Rooftop Heat Exchanger	2010	9,900		20	495	495	3,960	17
18	Satellite TV Install	2010	11,930		20	909	909	7,272	18
19	Paving Parking Lot	2010	12,000		20	600	600	4,800	19
20									20
21									21
22	Building Company Current Depreciation			68,530			(68,530)		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)		$ 749,210	$ 68,530		$ 37,772	$ (30,758)	$ 371,660	34

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

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 749,210	$ 68,530		$ 37,772	$	$ 371,660	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		$ 749,210	$ 68,530		$ 37,772	$	$ 371,660	34

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

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Generations Healthcare Network, LLC	2009	17,182	456	39	441	(15)	3,543	3
4	Allocated from S.I.R. Properties/GHN	1993	31,110	988	35	889	(99)	21,777	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Generations Healthcare Network, LLC	1993	7,887	220	20		(220)	7,887	9
10	Allocated from Generations Healthcare Network, LLC	1994	25		20			25	10
11	Allocated from Generations Healthcare Network, LLC	1995	180		20			180	11
12	Allocated from Generations Healthcare Network, LLC	1997	12,120	543	20	203	(340)	12,120	12
13	Allocated from Generations Healthcare Network, LLC	1999	953		20	48	48	869	13
14	Allocated from Generations Healthcare Network, LLC	2000	1,125		20	56	56	987	14
15	Allocated from Generations Healthcare Network, LLC	2007	3,615		20	181	181	1,843	15
16	Allocated from Generations Healthcare Network, LLC	2008	9,963	996	20	628	(368)	6,182	16
17	Allocated from Generations Healthcare Network, LLC	2009	24,756	226	20	1,238	1,012	10,205	17
18	Allocated from Generations Healthcare Network, LLC	2011	612	61	20	61		393	18
19	Allocated from Generations Healthcare Network, LLC	2012	1,960	98	20	98		545	19
20	Allocated from Generations Healthcare Network, LLC	2014	275	27	20	14	(13)	49	20
21	Allocated from Generations Healthcare Network, LLC	2016	357	18	20	18		25	21
22									22
23	Allocated from S.I.R. Properties/GHN	2012	1,906	83	20	95	12	477	23
24	Allocated from S.I.R. Properties/GHN	2010	1,877		20	94	94	688	24
25	Allocated from S.I.R. Properties/GHN	2009	1,868		20	93	93	822	25
26	Allocated from S.I.R. Properties/GHN	2007	184	11	20	9	(2)	101	26
27	Allocated from S.I.R. Properties/GHN	2002	123		20	6	6	96	27
28	Allocated from S.I.R. Properties/GHN	1999	3,942		20	197	197	3,646	28
29	Allocated from S.I.R. Properties/GHN	1994	296	8	20		(8)	296	29
30	Allocated from S.I.R. Properties/GHN	1993	505	3	20		(3)	505	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 122,821	$ 3,738		$ 4,369	$ 631	$ 73,261	34

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

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 122,821	$ 3,738		$ 4,369	$ 631	$ 73,261	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 122,821	$ 3,738		$ 4,369	$ 631	$ 73,261	34

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

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 1,217,222	$ 89,043	$ 122,351	$ 33,308	10	$ 1,028,131	71
72	Current Year Purchases	12,852		750	750	10	750	72
73	Fully Depreciated Assets	41,566		1,077	1,077	10	41,566	73
74								74
75	TOTALS	$ 1,271,640	$ 89,043	$ 124,178	$ 35,135		$ 1,070,447	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		GMAC VAN	2008	$ 30,038	$	$	$	5	$ 30,038	76
77		Allocated from Generations Heal	1900	2,416	211	159	(52)	5	2,018	77
78										78
79										79
80	TOTALS			$ 32,454	$ 211	$ 159	$ (52)		$ 32,056	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)	$ 5,753,394	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 262,315	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 279,161	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 16,846	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,529,919	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	HYUNDAI - 2010	$ 16,300	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 16,300	$	$	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.

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: *

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 4,567 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Generations Healthcare Network		$	$ 3,561	17
18					18
19					19
20					20
21	TOTAL		$	$ 3,561	21

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

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

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	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.

STATE OF ILLINOIS

Facility Name & ID Number Decatur Manor Healthcare **#** 0054239 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/17 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 416,079	$ 475,100	1
2	Cash-Patient Deposits	19,703	19,703	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	640,486	640,486	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,849	21,849	6
7	Other Prepaid Expenses	4,356	4,356	7
8	Accounts Receivable (owners or related parties)	350,000	350,000	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,452,473	$ 1,511,494	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,000	13
14	Buildings, at Historical Cost		2,902,875	14
15	Leasehold Improvements, at Historical Cost	429,203	1,100,849	15
16	Equipment, at Historical Cost	337,327	1,396,366	16
17	Accumulated Depreciation (book methods)	(381,884)	(2,335,342)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		12,443	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(74)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		1,450,000	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 384,646	$ 4,627,117	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,837,119	$ 6,138,611	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 131,399	$ 131,400	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,723	19,723	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	67,374	67,374	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,917	3,917	31
32	Accrued Real Estate Taxes(Sch.IX-B)		55,600	32
33	Accrued Interest Payable		7,147	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	333,639	333,639	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 556,052	$ 618,800	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,176,575	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule		63,786	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,240,361	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 556,052	$ 4,859,161	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,281,067	$ 1,279,450	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,837,119	$ 6,138,611	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,194,001	1
2	Restatements (describe):		2
3	Rounding	4	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,194,005	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	770,762	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	(1,683,700)	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)**	$ (912,938)	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)**	$ 1,281,067	24 *

*** This must agree with page 17, line 47.**

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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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,003,128	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,003,128	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	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	15,929	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 15,929	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	55,410	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 55,410	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	2,294	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,294	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,076,761	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,031,320	31
32	Health Care	1,446,279	32
33	General Administration	1,329,084	33
	B. Capital Expense		
34	Ownership	499,316	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,305,999	40
41	**Income before Income Taxes (line 30 minus line 40)****	770,762	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 770,762	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,331,538	44
45	Private Pay - Net Inpatient Revenue	86,845	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Managed Care	479,557	47
48	Other-(specify) Veterans	105,188	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,003,128	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis 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.**

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,089	2,194	$ 81,125	$ 36.98	1
2	Assistant Director of Nursing	1,967	2,164	66,889	30.91	2
3	Registered Nurses	2,051	2,215	58,447	26.39	3
4	Licensed Practical Nurses	11,829	12,520	281,657	22.50	4
5	CNAs & Orderlies	46,172	48,077	483,968	10.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,549	7,025	66,977	9.53	10
11	Social Service Workers	10,408	10,929	165,205	15.12	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,774	18,272	178,527	9.77	15
16	Dishwashers					16
17	Maintenance Workers	3,712	4,038	59,551	14.75	17
18	Housekeepers	12,434	13,173	145,045	11.01	18
19	Laundry	3,626	3,932	35,991	9.15	19
20	Administrator	1,900	2,086	129,051	61.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,138	8,617	103,966	12.07	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	2,149	2,249	24,141	10.73	31
32	Other Health Care(specify)					32
33	Other(specify)	3,263	3,263	13,456	4.12	33
34	TOTAL (lines 1 - 33)	134,061	140,754	$ 1,893,996 *	$ 13.46	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 29,921	01-03	35
36	Medical Director				36
37	Medical Records Consultant	Monthly	1,125	10-03	37
38	Nurse Consultant	Monthly	43,224	10-03	38
39	Pharmacist Consultant	Monthly	12,098	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,100	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psych Medical Director	Monthly	48,000	12-03	47
48	Specialized Rehab Consultant	Monthly	25,140	10a-03	48
49	TOTAL (lines 35 - 48)		$ 160,608		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ruth Huber	Administrator	0	$ 129,051
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 129,051

B. Administrative - Other

Description	Amount
Generations Healthcare Network	$ 43,224
Generations Healthcare Network	36,168
Generations Healthcare Network	249,726
TOTAL (agree to Schedule V, line 17, col. 3)	$ 329,118
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Generations Healthcare Network	Dir. Of Financial Services	$ 42,000
Generations Healthcare Network	Dir. Of Marketing & Admissions	30,600
Generations Healthcare Network	Dir. Of Regulatory Services	21,612
Generations Healthcare Network	Dir. Of IT	9,000
Marcum LLP	Accounting Fees	15,925
Plante & Moran LLC	Accounting Fees	1,125
RSM US LLP	Accounting Fees	1,751
Generations Healthcare Network	Bookkeeping Services	66,588
Generations Healthcare Network	Computer Support Charges	19,848
See Attached	Legal Fees	4,309
Personnel Planners	Unemployment Tax Consulting	1,766
See Supplemental Schedule		18,328
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 232,852

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 28,780
Unemployment Compensation Insurance	13,545
FICA Taxes	139,351
Employee Health Insurance	62,524
Employee Meals	6,753
Illinois Municipal Retirement Fund (IMRF)*	
401K Contribution	3,985
TOTAL (agree to Schedule V, line 22, col.8)	$ 254,937

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	$ 3,814
Advertising: Employee Recruitment	6,221
Health Care Worker Background Check	
(Indicate # of checks performed 86)	860
Patient Background Checks 436.7	4,367
Dues & Subscriptions	15,625
Licenses & Permits	2,399
Allocated from Generations Healthcare Netwo	261
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 33,547

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,726
Allocated from Generations Healthcare Netwo	158
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,884

* Attach copy of IMRF notifications

**See instructions.

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Alliance for Living - $19,068**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,739** 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. $
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? **Yes** 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. $ **6,753** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
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