FOR BHF USE

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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

I. IDPH License ID Number: 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 01/01/18 to 12/31/18 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)
** Subject to the attached Accountants' Consulting Report* (Date)
(Print Name and Title) Steven N. Lavenda, CPA, Partner
(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: 01/01/18 Ending: 12/31/18

III. STATISTICAL DATA

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

	1 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	33,530	493	12,720	46,743	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,530	493	12,720	46,743	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.12%

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 _____

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	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	173,519	25,651	24,495	223,665		223,665	(6,734)	216,931			1
2	Food Purchase		280,614		280,614	(7,081)	273,533	(2,425)	271,108			2
3	Housekeeping	147,673	32,293		179,966		179,966	(2,858)	177,108			3
4	Laundry	37,327	10,995		48,322		48,322	(37)	48,285			4
5	Heat and Other Utilities			125,615	125,615		125,615	(30,075)	95,540			5
6	Maintenance	61,800	24,386	118,728	204,914		204,914	(14,565)	190,349			6
7	Other (specify):*							2,785	2,785			7
8	**TOTAL General Services**	420,319	373,939	268,838	1,063,096	(7,081)	1,056,015	(53,910)	1,002,105			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	977,069	58,969	47,398	1,083,436		1,083,436	(36,321)	1,047,115			10
10a	Therapy			28,224	28,224		28,224	(9,335)	18,889			10a
11	Activities	64,436	17,828	325	82,589		82,589		82,589			11
12	Social Services	255,243		48,000	303,243		303,243		303,243			12
13	CNA Training											13
14	Program Transportation			221	221		221		221			14
15	Other (specify):*							9,042	9,042			15
16	**TOTAL Health Care and Programs**	1,296,748	76,797	124,168	1,497,713		1,497,713	(36,614)	1,461,099			16
	C. General Administration											
17	Administrative	114,521		349,493	464,014		464,014	(228,375)	235,639			17
18	Directors Fees											18
19	Professional Services			256,665	256,665	(66)	256,599	(167,222)	89,377			19
20	Dues, Fees, Subscriptions & Promotions			83,185	83,185		83,185	(61,080)	22,105			20
21	Clerical & General Office Expenses	70,022	30,430	52,689	153,141		153,141	88,932	242,073			21
22	Employee Benefits & Payroll Taxes			265,230	265,230	7,081	272,311		272,311			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,399	9,399		9,399	227	9,626			24
25	Other Admin. Staff Transportation			10,056	10,056		10,056	14,482	24,538			25
26	Insurance-Prop.Liab.Malpractice			120,535	120,535		120,535	1,474	122,009			26
27	Other (specify):*							31,068	31,068			27
28	**TOTAL General Administration**	184,543	30,430	1,147,252	1,362,225	7,015	1,369,240	(320,494)	1,048,746			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,901,610	481,166	1,540,258	3,923,034	(66)	3,922,968	(411,018)	3,511,950			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: 01/01/18 Ending: 12/31/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			54,055	54,055		54,055	224,504	278,559			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,356	2,356		2,356	170,183	172,539			32
33	Real Estate Taxes					66	66	58,459	58,525			33
34	Rent-Facility & Grounds			552,000	552,000		552,000	(552,000)				34
35	Rent-Equipment & Vehicles			3,480	3,480		3,480	3,419	6,899			35
36	Other (specify):*											36
37	**TOTAL Ownership**			611,891	611,891	66	611,957	(95,435)	516,522			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)**	1,901,610	481,166	2,152,149	4,534,925		4,534,925	(506,453)	4,028,472			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: 01/01/18 Ending: 12/31/18

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	(31,771)	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	33,222	30		9
10	Interest and Other Investment Income	(40,681)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(30)	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	(43,367)	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	(15,283)	21		24
25	Fund Raising, Advertising and Promotional	(7,500)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(81,961)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (187,371)		$	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)	(319,082)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (319,082)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (506,453)		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: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Pescription Drugs	$ (31,129)	10	1
2	Bank Fees	(7,087)	21	2
3	Theft & Damages Loss	(189)	21	3
4	State Replacement Tax	(6,803)	21	4
5	PAC DUES	(10,304)	20	5
6	Caopitalized R & M	(15,242)	06	6
7	Non-Allowable Legal	(6,955)	19	7
8	Vending Machine Income	(2,395)	02	8
9	Building Co. - Filing Fees	(75)	21	9
10	Building Co. - Office Expenses	(4)	21	10
11	Building Co. - Amortization	(1,778)	36	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(81,961)		49

Decatur Manor Healthcare

ID# 0054239

Report Period Beginning: 01/01/18

Ending: 12/31/18

	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: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(6,734)								(6,734)	1
2	Food Purchase	(2,425)											(2,425)	2
3	Housekeeping						(2,858)						(2,858)	3
4	Laundry						(37)						(37)	4
5	Heat and Other Utilities	(31,771)			1,696								(30,075)	5
6	Maintenance	(15,242)		(1,215)	1,892								(14,565)	6
7	Other (specify):*			992	1,793								2,785	7
8	**TOTAL General Services**	(49,438)		(223)	(1,353)		(2,895)						(53,910)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(31,129)		(6,490)	6,374	(2,438)	(2,638)						(36,321)	10
10a	Therapy				(9,335)								(9,335)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			4,814	4,228								9,042	15
16	**TOTAL Health Care and Programs**	(31,129)		(1,676)	1,267	(2,438)	(2,638)						(36,614)	16
	C. General Administration													
17	Administrative			(327,062)	98,687								(228,375)	17
18	Directors Fees													18
19	Professional Services	(6,955)		(172,232)	11,965								(167,222)	19
20	Fees, Subscriptions & Promotions	(61,171)		91									(61,080)	20
21	Clerical & General Office Expenses	(29,441)	79	118,204	90								88,932	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			227									227	24
25	Other Admin. Staff Transportation			14,482									14,482	25
26	Insurance-Prop.Liab.Malpractice			1,264	210								1,474	26
27	Other (specify):*			7,970	23,098								31,068	27
28	**TOTAL General Administration**	(97,567)	79	(357,056)	134,050								(320,494)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(178,134)	79	(358,955)	133,963	(2,438)	(5,533)						(411,018)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	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	33,222	186,723		4,559								224,504	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(40,681)	230,388	(23,657)	4,133								170,183	32
33	Real Estate Taxes		51,891		6,568								58,459	33
34	Rent-Facility & Grounds		(552,000)										(552,000)	34
35	Rent-Equipment & Vehicles			3,419									3,419	35
36	Other (specify):*	(1,778)	1,778											36
37	TOTAL Ownership	(9,237)	(81,220)	(20,238)	15,260								(95,435)	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)	(187,371)	(81,141)	(379,193)	149,223	(2,438)	(5,533)						(506,453)	45

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 552,000	Decatur Healthcare Estates		$	$ (552,000)	1
2	V	21	Filling Fees		Decatur Healthcare Estates		75	75	2
3	V	32	Interest Expense		Decatur Healthcare Estates		232,108	232,108	3
4	V	21	Office		Decatur Healthcare Estates		4	4	4
5	V	33	Real Estate Taxes		Decatur Healthcare Estates		54,800	54,800	5
6	V	33	Real Estate Taxes - Prior	2,909	Decatur Healthcare Estates			(2,909)	6
7	V	32	Interest Income	1,720	Decatur Healthcare Estates			(1,720)	7
8	V	36	Amortization - Loan Fees		Decatur Healthcare Estates		1,778	1,778	8
9	V	30	Depreciation		Decatur Healthcare Estates		186,723	186,723	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 556,629			$ 475,488	$ * (81,141)	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: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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.	$ 12,348	GENERATIONS HC NETWORK, LLC		$ 11,133	$ (1,215)	15
16	V	7	EMP. BEN.-GEN. SERV.		GENERATIONS HC NETWORK, LLC		992	992	16
17	V	9	MEDICAL DIRECTOR CONSULTS		GENERATIONS HC NETWORK, LLC				17
18	V	10	NURSING	35,280	GENERATIONS HC NETWORK, LLC		28,790	(6,490)	18
19	V	15	EMP. BEN.-H.C.		GENERATIONS HC NETWORK, LLC		4,814	4,814	19
20	V	17	ADMINISTRATIVE	349,493	GENERATIONS HC NETWORK, LLC		22,431	(327,062)	20
21	V	19	PROFESSIONAL FEES	181,176	GENERATIONS HC NETWORK, LLC		8,944	(172,232)	21
22	V	20	FEES,SUBSCRIPTIONS		GENERATIONS HC NETWORK, LLC		91	91	22
23	V	21	CLERICAL & GENERAL	7,944	GENERATIONS HC NETWORK, LLC		126,148	118,204	23
24	V	24	EDUCATION & SEMINAR		GENERATIONS HC NETWORK, LLC		227	227	24
25	V	25	OTHER ADMIN. STAFF TRANS.		GENERATIONS HC NETWORK, LLC		14,482	14,482	25
26	V	26	INSURANCE		GENERATIONS HC NETWORK, LLC		1,264	1,264	26
27	V	27	EMP. BEN.-GEN. ADMIN.		GENERATIONS HC NETWORK, LLC		7,970	7,970	27
28	V	32	INTEREST		GENERATIONS HC NETWORK, LLC		(23,657)	(23,657)	28
29	V	35	AUTO RENTAL		GENERATIONS HC NETWORK, LLC		2,757	2,757	29
30	V	35	EQUIPMENT RENTAL		GENERATIONS HC NETWORK, LLC		662	662	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			$ 586,241			$ 207,048	$ * (379,193)	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: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	$ 12,348	GENERATIONS HC NETWORK, LLC		$ 5,614	$ (6,734)	15
16	V	7	EMP. BEN.-DIETARY		GENERATIONS HC NETWORK, LLC		940	940	16
17	V	10	NURSING SALARIES		GENERATIONS HC NETWORK, LLC		6,374	6,374	17
18	V	15	EMP. BEN.-NURSING		GENERATIONS HC NETWORK, LLC		1,060	1,060	18
19	V	17	ADMIN./LEGAL SALARIES		GENERATIONS HC NETWORK, LLC		98,687	98,687	19
20	V	19	FIN. CONSULT./REGL. DIR.		GENERATIONS HC NETWORK, LLC		11,712	11,712	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		GENERATIONS HC NETWORK, LLC		23,098	23,098	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	28,224	GENERATIONS HC NETWORK, LLC		18,889	(9,335)	24
25	V	15	EMPLOYEE BENFITS		GENERATIONS HC NETWORK, LLC		3,168	3,168	25
26	V								26
27	V	6	MAINTENANCE SALARIES	3,920	GENERATIONS HC NETWORK, LLC		4,831	911	27
28	V	7	EMPLOYEE BENEFITS		GENERATIONS HC NETWORK, LLC		853	853	28
29	V								29
30	V	5	UTILITIES		GENERATIONS HC NETWORK, LLC		1,696	1,696	30
31	V	6	REPAIRS AND MAINT.		GENERATIONS HC NETWORK, LLC		981	981	31
32	V	19	PROFESSIONAL FEES		GENERATIONS HC NETWORK, LLC		253	253	32
33	V	21	CLERICAL & GENERAL		GENERATIONS HC NETWORK, LLC		90	90	33
34	V	26	INSURANCE		GENERATIONS HC NETWORK, LLC		210	210	34
35	V	30	DEPRECIATION		GENERATIONS HC NETWORK, LLC		4,559	4,559	35
36	V	32	INTEREST		GENERATIONS HC NETWORK, LLC		4,133	4,133	36
37	V	33	REAL ESTATE TAXES		GENERATIONS HC NETWORK, LLC		6,568	6,568	37
38	V								38
39	Total			$ 44,492			$ 193,715	$ * 149,223	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: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	06	Maintenance	$	MAC Rx, LLC		$	$	15
16	V	10	Nursing and Medical Records	28,285	MAC Rx, LLC		25,847	(2,438)	16
17	V	10A	Therapy		MAC Rx, LLC				17
18	V	19	Professional Services		MAC Rx, LLC				18
19	V	21	Clerical & General Office Expenses		MAC Rx, LLC				19
20	V	22	Employee Benefits		MAC Rx, LLC				20
21	V	39	Ancillary		MAC Rx, LLC				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			$ 28,285			$ 25,847	$ * (2,438)	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: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	$	Big Ten Supply, LLC	100.00%	$	$	15
16	V	3	Housekeeping	29,844	Big Ten Supply, LLC	100.00%	26,987	(2,858)	16
17	V	4	Laundry	390	Big Ten Supply, LLC	100.00%	353	(37)	17
18	V	6	Repairs & Maintenance		Big Ten Supply, LLC	100.00%			18
19	V	10	Nursing And Medical Records	27,549	Big Ten Supply, LLC	100.00%	24,910	(2,638)	19
20	V	10A	Therapy		Big Ten Supply, LLC	100.00%			20
21	V	21	Clerical & General		Big Ten Supply, LLC	100.00%			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			$ 57,783			$ 52,250	$ * (5,533)	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: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 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: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 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: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 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: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 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: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

1 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: 01/01/18 Ending: 12/31/18

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%	AUBURN VILLAGE	AUBURN, IN	6631 MILWAUKEE, LLC	LINCOLNWOOD	BUILDING CO.	1
2	BARRISH GROUP LIMITED	8.80%	ALBANY CARE, INC.	EVANSTON	GENERATIONS HEALTH NETW	LINCOLNWOOD	CONSULTING CO.	2
3	BRYAN BARRISH TRUST	8.80%	BRYN MAWR CARE INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	FAY CHIN	1.34%	DECATUR MANOR HEALTHCARE,LLC	DECATUR	OAKTON ARMS	DES PLAINES	ASSISTED LIVING	4
5	JEFF ORAVEC	1.34%	GENERATIONS AT APPLEWOOD, LLC	MATTESON	MAC Rx LLC	DES PLAINES	PHARMACY CONS	5
6	LOUISE BERGTHOLD	3.36%	GENERATIONS AT COLUMBUS PARK, INC	CHICAGO	BIG TEN SUPPLY, LLC	LIBERTYVILLE	SUPPLY CO.	6
7	LYNN ETHELL	1.34%	GENERATIONS AT ELMWOOD PARK, INC	ELMWOOD PARK	DECATUR HEALTHCARE ESTATES		BUILDING CO.	7
8	NENITA GUZMAN	1.34%	GENERATIONS AT NEIGHBORS, LLC	BYRON				8
9	PATRICIA MCDIARMID	1.34%	GENERATIONS AT OAKTON PAVILION, LLC	DES PLAINES				9
10	RALPH GESUALDO	8.80%	GENERATIONS AT REGENCY, LLC	NILES				10
11	RALPH GESUALDO CHILDREN'S TRUST	8.80%	GENERATIONS AT ROCK ISLAND, LLC	ROCK ISLAND				11
12	RONALD NUNZIATO JR.	2.68%	GREENWOOD CARE, INC.	EVANSTON				12
13	THOMAS & STEPHANIE WINTER REV. TRUST	6.71%	WILSON CARE, INC.	CHICAGO				13
14	UNITED TRUST #1	4.40%	GENERATIONS AT LINCOLN, LLC	LINCOLN				14
15	UNITED TRUST #2	4.40%	GENERATIONS AT MCKINLEY COURT, LLC	DECATUR				15
16	L.G. TRUST	4.39%	GENERATIONS AT MCKINLEY PLACE, LLC	DECATUR				16
17	B.G. TRUST	4.39%	GENERATIONS AT PEORIA, LLC	PEORIA				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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

	1	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	2.01	5.03%	Alloc. Salary	$ 14,366	17-7	1
2	Sarah Barrish	Relative	Administrative		See Attached	2.87	5.75%	Alloc. Salary	7,225	17-7	2
3	Louise Bergthold	Shareholder	Administrative	3.36%	See Attached	3.45	5.75%	Alloc. Salary	14,366	17-7	3
4	Thomas Bergthold	Relative	Clerical		See Attached	2.3	5.75%	Alloc. Salary	2,842	21-7	4
5	Andrew Chin	Relative	Clerical		See Attached	2.3	5.75%	Alloc. Salary	4,822	21-7	5
6	Fay Chin	Shareholder	Nursing	1.34%	See Attached	2.3	5.75%	Alloc. Salary	6,374	10-7	6
7	Clark Collins	Relative	Administrative		See Attached	0.82	2.04%	Alloc. Salary	1,022	Var.	7
8	Lynn Ethell	Shareholder	Clerical	1.34%	See Attached	1.72	5.75%	Alloc. Salary	2,911	21-7	8
9	Mike Giannini	Relative	Administrative		See Attached	2.01	5.03%	Alloc. Salary	10,389	17-7	9
10	Nenita Guzman	Shareholder	Dietary	1.34%	See Attached	2.87	5.75	Alloc. Salary	5,614	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.										12
13								TOTAL	$ 69,931		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: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [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: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	813,429	20	$ 193,743	$ 103,385	46,743	$ 11,133	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	813,429	20	17,260		46,743	992	2
3	9	MEDICAL DIRECTOR CONSUL	PATIENT DAYS	813,429	20			46,743		3
4	10	NURSING	PATIENT DAYS	813,429	20	501,001	501,001	46,743	28,790	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	813,429	20	83,773		46,743	4,814	5
6	17	ADMINISTRATIVE	PATIENT DAYS	813,429	20	390,351	390,351	46,743	22,431	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	813,429	20	155,641		46,743	8,944	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	813,429	20	1,590		46,743	91	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	813,429	20	2,195,251	1,959,905	46,743	126,148	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	813,429	20	3,956		46,743	227	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	813,429	20	252,011		46,743	14,482	11
12	26	INSURANCE	PATIENT DAYS	813,429	20	21,989		46,743	1,264	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	813,429	20	138,692		46,743	7,970	13
14	32	INTEREST	PATIENT DAYS	813,429	20	(411,674)		46,743	(23,657)	14
15	35	AUTO RENTAL	PATIENT DAYS	813,429	20	47,983		46,743	2,757	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	813,429	20	11,512		46,743	662	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,603,079	$ 2,954,641		$ 207,048	25

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	813,429	20	$ 97,690	$ 97,690	46,743	$ 5,614	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	813,429	20	16,359		46,743	940	2
3	10	NURSING SALARIES	PATIENT DAYS	813,429	20	110,913	110,913	46,743	6,374	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	813,429	20	18,452		46,743	1,060	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	813,429	20	1,717,366	1,717,366	46,743	98,687	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	813,429	20	203,820		46,743	11,712	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	813,429	20	401,962		46,743	23,098	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	284,688	14	190,531	190,531	28,224	18,889	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	284,688	14	31,950		28,224	3,168	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	368,277	19	453,836	453,836	3,920	4,831	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	368,277	19	80,131		3,920	853	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	20	29,526		740	1,696	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	20	17,073		740	981	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	20	4,403		740	253	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	20	1,572		740	90	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	20	3,650		740	210	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	20	79,352		740	4,559	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	20	71,924		740	4,133	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	20	114,307		740	6,568	23
24										24
25	TOTALS					$ 3,644,817	$ 2,570,336		$ 193,715	25

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance	Direct Allocation			$	$		$	1
2	10	Nursing And Medical Records	Direct Allocation						25,847	2
3	10A	Therapy	Direct Allocation							3
4	19	Professional Services	Direct Allocation							4
5	21	Clerical & General Office Expens	Direct Allocation							5
6	22	Employee Benefits	Direct Allocation							6
7	39	Ancillary	Direct Allocation							7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 25,847	25

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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			$	$		$	1
2	3	Housekeeping	Direct Allocation						26,987	2
3	4	Laundry	Direct Allocation						353	3
4	6	Repairs & Maintenance	Direct Allocation							4
5	10	Nursing And Medical Records	Direct Allocation						24,910	5
6	10A	Therapy	Direct Allocation							6
7	21	Clerical & General	Direct Allocation							7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 52,250	25

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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: 01/01/18 Ending: 12/31/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Centure Bank		X	Mortgage			$	$ 3,994,652			$ 232,108	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Lake Forest Bank & Trust		X	Line of Credit				385,000			2,356	6
7												7
8												8
9	TOTAL Facility Related						$	$ 4,379,652			$ 234,464	9
	B. Non-Facility Related*											
10	Interest Income		X								(40,681)	10
11	Interest Income - Bldg Co		X								(1,720)	11
12	Allocated from Generations Hea	X									4,133	12
13	See Supplemental Schedule										(23,657)	13
14	TOTAL Non-Facility Related						$	$			$ (61,925)	14
15	TOTALS (line 9+line14)						$	$ 4,379,652			$ 172,539	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: 01/01/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 55,600	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.)		$ 59,259	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,659	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 54,800	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.)		$ 66	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.		$ 58,525	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	46,700	8
	2014	47,598	9
	2015	50,791	10
	2016	53,206	11
	2017	52,691	12

2018 Accrual = $52,691 x 1.04 = 54,800

Allocated from Generations Healthcare Network: $6,568

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Decatur Manor Healthcare COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0054239

CONTACT PERSON REGARDING THIS REPORT

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

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

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

	(A) 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	$ 52,691.48	$ 52,691.48
2.	10-31-401-046-0000	Allocated by Regency Property	$ 899,389.48	$ 313.94
3.	See Attached	Allocated by S.I.R. Properties	$ 137,812.17	$ 6,201.34
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,089,893.13	$ 59,206.76

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

IMPORTANT NOTICE

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

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

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

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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Decatur Manor Healthcare COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0054239

CONTACT PERSON REGARDING THIS REPORT

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

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

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

	(A) 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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/18 Ending: 12/31/18

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			$ 100,000	3

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 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	$ 186,723	35	$ 82,939	$ (103,784)	$ 900,721	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2008	11,477		20	443	443	11,477	9
10	Various			2009	26,920		20	1,346	1,346	12,715	10
11	Various			2010	26,169		20	1,508	1,508	18,461	11
12	Various			2011	83,931		20	4,474	4,474	32,507	12
13	Various			2012	253,113		20	12,656	12,656	83,768	13
14	Various			2013	36,564		20	1,828	1,828	10,118	14
15	Various			2014	54,289		20	3,039	3,039	13,358	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: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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)		810,920			40,858	40,858	412,518	67
68	Related Party Allocations (Pages 12H & 12I)		102,683	2,231		3,266	1,035	64,502	68
69	Financial Statement Depreciation			54,055			(54,055)		69
70	TOTAL (lines 4 thru 69)		$ 4,308,941	$ 243,009		$ 152,355	$ (90,654)	$ 1,560,144	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: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,308,941	$ 243,009		$ 152,355	$ (90,654)	$ 1,560,144	1
2	Hot Water Heater	2015	5,325		20	266	266	1,065	2
3	Roof Work (West)	2015	10,350		20	518	518	1,898	3
4	Hot Water Heater	2015	10,956		20	548	548	1,826	4
5	Laminate Flooring (4 Rooms)	2015	6,590		20	330	330	1,071	5
6	Wireless Network	2015	6,988		20	349	349	1,165	6
7	1 Hp Sump Pump	2016	6,865		20	343	343	1,001	7
8	Storage Shed With Concrete Pad	2016	10,006		20	500	500	1,376	8
9	Furnace	2016	4,226		20	211	211	458	9
10	Wiring Magnet Front Door	2016	3,075		20	154	154	436	10
11	Furnace For E-Wing	2017	5,265		20	263	263	505	11
12	Front Door Alarm	2017	4,064		20	203	203	339	12
13	Furnace For G-Wing	2017	5,699		20	285	285	309	13
14	Hvac Repairs	2017	2,522		20	126	126	221	14
15	Remove Ceiling In Room And Bathroom/Light Fixtures/Paint	2018	3,415		20	171	171	171	15
16	Installed Drywall On Walls & Ceiling	2018	3,680		20	184	184	184	16
17	Tree Removal And Replacements	2018	8,147		20	407	407	407	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,406,114	$ 243,009		$ 157,213	$ (85,796)	$ 1,572,574	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: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,406,114	$ 243,009		$ 157,213	$ (85,796)	$ 1,572,574	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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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)		$ 4,406,114	$ 243,009		$ 157,213	$ (85,796)	$ 1,572,574	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: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,406,114	$ 243,009		$ 157,213	$ (85,796)	$ 1,572,574	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)		$ 4,406,114	$ 243,009		$ 157,213	$ (85,796)	$ 1,572,574	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: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 4,406,114	$ 243,009		$ 157,213	$ (85,796)	$ 1,572,574	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)		$ 4,406,114	$ 243,009		$ 157,213	$ (85,796)	$ 1,572,574	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: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Roof	2008	83,141		20	4,157	4,157	45,727	9
10	Hand Rails	2008	41,519		20	2,076	2,076	22,836	10
11	Demolition, Framing,Plumbing, Heating…	2008	71,200		20	3,560	3,560	39,160	11
12	Demolition, Electical,Plumbing, Painting,Flooring….	2008	455,946		20	22,797	22,797	250,767	12
13	Painting Doors	2008	7,840		20	392	392	4,312	13
14	Draperies	2008	35,206		20	1,760	1,760	19,360	14
15	Trane A/C Unit	2010	12,989		20	649	649	5,841	15
16	Fire Alarm	2010	7,539		20	377	377	3,393	16
17	Rooftop Heat Exchanger	2010	9,900		20	495	495	4,455	17
18	Satellite TV Install	2010	11,930		20	909	909	8,181	18
19	Paving Parking Lot	2010	12,000		20	600	600	5,400	19
20	Basketball Court	2018	14,482		20	724	724	724	20
21	HVAC Condenser	2018	3,844		20	192	192	192	21
22	Patio Construction	2018	9,099		20	455	455	455	22
23	Breakroom Remodel	2018	2,935		20	147	147	147	23
24	HVAC Replacement	2018	12,110		20	606	606	606	24
25	Furnace Condenser & Coils	2018	19,240		20	962	962	962	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 810,920	$		$ 40,858	$ 40,858	$ 412,518	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: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 810,920	$		$ 40,858	$ 40,858	$ 412,518	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 810,920	$		$ 40,858	$	$ 412,518	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: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party								1
2	Buildings:								2
3	Allocated from Generations Healthcare Network, LLC	2009	14,364	387	39	368	(19)	3,330	3
4	Allocated from S.I.R. Properties/GHN	1993	26,009	826	35	743	(83)	18,949	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Generations Healthcare Network, LLC	1993	6,594	184	20		(184)	6,594	9
10	Allocated from Generations Healthcare Network, LLC	1994	21		20			21	10
11	Allocated from Generations Healthcare Network, LLC	1995	151		20			151	11
12	Allocated from Generations Healthcare Network, LLC	1997	10,132	227	20		(227)	10,132	12
13	Allocated from Generations Healthcare Network, LLC	1999	797		20	40	40	766	13
14	Allocated from Generations Healthcare Network, LLC	1999							14
15	Allocated from Generations Healthcare Network, LLC	2000	941		20	47	47	872	15
16	Allocated from Generations Healthcare Network, LLC	2007	3,022		20	151	151	1,692	16
17	Allocated from Generations Healthcare Network, LLC	2008	8,329	160	20	308	148	5,476	17
18	Allocated from Generations Healthcare Network, LLC	2009	20,697	189	20	1,035	846	9,567	18
19	Allocated from Generations Healthcare Network, LLC	2011	512	51	20	51		380	19
20	Allocated from Generations Healthcare Network, LLC	2012	1,639	82	20	82		526	20
21	Allocated from Generations Healthcare Network, LLC	2014	230	23	20	11	(11)	53	21
22	Allocated from Generations Healthcare Network, LLC	2016	299	15	20	15		36	22
23	Allocated from Generations Healthcare Network, LLC	2018							23
24									24
25	Allocated from S.I.R. Properties/GHN	2012	1,593	70	20	80	10	479	25
26	Allocated from S.I.R. Properties/GHN	2010	1,570		20	78	78	654	26
27	Allocated from S.I.R. Properties/GHN	2009	1,562		20	78	78	765	27
28	Allocated from S.I.R. Properties/GHN	2007	154	9	20	8	(1)	92	28
29	Allocated from S.I.R. Properties/GHN	2002	103		20	5	5	85	29
30	Allocated from S.I.R. Properties/GHN	1999	3,296		20	165	165	3,213	30
31	Allocated from S.I.R. Properties/GHN	1994	248	6	20		(6)	248	31
32	Allocated from S.I.R. Properties/GHN	1993	422	2	20		(2)	422	32
33									33
34	TOTAL (lines 1 thru 33)		$ 102,683	$ 2,231		$ 3,266	$ 1,035	$ 64,502	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: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 102,683	$ 2,231		$ 3,266	$ 1,035	$ 64,502	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 102,683	$ 2,231		$ 3,266	$ 1,035	$ 64,502	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: 01/01/18 Ending: 12/31/18

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	$ 1,195,343	$ 2,010	$ 118,286	$ 116,277	10	$ 1,114,376	71
72	Current Year Purchases	25,134	46	2,353	2,307	10	2,353	72
73	Fully Depreciated Assets	61,053		381	381	10	61,053	73
74								74
75	TOTALS	$ 1,281,530	$ 2,056	$ 121,021	$ 118,965		$ 1,177,782	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	2018	4,328	273	325	52	5	2,013	77
78										78
79										79
80	TOTALS			$ 34,366	$ 273	$ 325	$ 52		$ 32,051	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)	$ 5,822,010	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 245,338	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 278,560	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 33,222	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,782,406	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: 01/01/18 Ending: 12/31/18

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 4,142 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		$	$ 2,757	17
18					18
19					19
20					20
21	TOTAL		$	$ 2,757	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: 01/01/18 Ending: 12/31/18

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

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

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: 01/01/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 58,377	$ 204,005	1
2	Cash-Patient Deposits	38,167	38,167	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	644,871	644,871	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,023	3,023	6
7	Other Prepaid Expenses	2,457	2,457	7
8	Accounts Receivable (owners or related parties)	1,761,954	1,680,000	8
9	Other(specify): See Attached Schedule	9,000	9,000	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,517,849	$ 2,581,523	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	1,162,559	15
16	Equipment, at Historical Cost	341,636	1,420,919	16
17	Accumulated Depreciation (book methods)	(435,939)	(2,576,120)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		12,443	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(1,852)	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)**	$ 334,900	$ 4,470,824	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,852,749	$ 7,052,347	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 393,827	$ 393,828	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	38,299	38,299	28
29	Short-Term Notes Payable	385,000	385,000	29
30	Accrued Salaries Payable	73,406	73,406	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,522	4,522	31
32	Accrued Real Estate Taxes(Sch.IX-B)		54,800	32
33	Accrued Interest Payable		6,835	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	371,501	371,501	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,266,555	$ 1,328,191	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,994,652	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)**	$	$ 4,058,438	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,266,555	$ 5,386,629	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,586,194	$ 1,665,718	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,852,749	$ 7,052,347	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,281,067	1
2	Restatements (describe):		2
3	Rounding	9	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,281,076	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	662,718	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	(357,600)	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)**	$ 305,118	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,586,194	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	$ 5,130,729	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,130,729	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	22,977	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)**	$ 22,977	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	40,681	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 40,681	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	3,256	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,256	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,197,643	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,063,096	31
32	Health Care	1,497,713	32
33	General Administration	1,362,225	33
	B. Capital Expense		
34	Ownership	611,891	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)***	$ 4,534,925	40
41	**Income before Income Taxes (line 30 minus line 40)****	662,718	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 662,718	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,601,744	44
45	Private Pay - Net Inpatient Revenue	107,250	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Manage Care	1,298,781	47
48	Other-(specify) Veterans	122,954	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,130,729	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	1,893	2,086	$ 79,193	$ 37.96	1
2	Assistant Director of Nursing	1,943	2,089	67,437	32.28	2
3	Registered Nurses	1,927	1,984	55,877	28.16	3
4	Licensed Practical Nurses	12,086	12,800	294,793	23.03	4
5	CNAs & Orderlies	42,412	44,487	453,675	10.20	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,182	6,555	64,436	9.83	10
11	Social Service Workers	15,584	16,476	243,927	14.80	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,302	17,812	173,519	9.74	15
16	Dishwashers					16
17	Maintenance Workers	3,730	4,034	61,800	15.32	17
18	Housekeepers	12,434	13,175	147,673	11.21	18
19	Laundry	3,711	3,962	37,327	9.42	19
20	Administrator	1,918	2,086	114,521	54.90	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,092	6,370	70,022	10.99	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	2,015	2,115	26,094	12.34	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	2,744	2,744	11,316	4.12	33
34	TOTAL (lines 1 - 33)	131,973	138,775	$ 1,901,610 *	$ 13.70	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	$ 24,495	01-03	35
36	Medical Director				36
37	Medical Records Consultant	Monthly	1,063	10-03	37
38	Nurse Consultant	Monthly	35,280	10-03	38
39	Pharmacist Consultant	Monthly	11,055	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	325	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	28,224	10a-03	48
49	TOTAL (lines 35 - 48)		$ 148,442		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	$ 114,521
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 114,521

B. Administrative - Other

Description	Amount
Generations Healthcare Network - Dir. Of Admin. Services	$ 49,392
Generations Healthcare Network - Ancillary Admin. Services	44,100
Generations Healthcare Network - Consulting Fees	256,001
TOTAL (agree to Schedule V, line 17, col. 3)	$ 349,493
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Generations Healthcare Network	Dir. Of Financial Services	$ 48,876
Generations Healthcare Network	Dir. Of Business Development	35,280
Generations Healthcare Network	Dir. Of Regulatory Services	15,876
Generations Healthcare Network	Dir. Of IT	10,584
Marcum LLP	Accounting Fees	15,650
Plante & Moran LLC	Accounting Fees	1,950
RSM US LLP	Accounting Fees	1,125
Generations Healthcare Network	Bookkeeping Services	70,560
Generations Healthcare Network	Computer Support Charges	22,932
See Attached	Legal Fees	11,036
Personnel Planners	Unemployment Tax Consulting	913
See Supplemental Schedule		21,882
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 256,664

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 25,675
Unemployment Compensation Insurance	15,211
FICA Taxes	140,792
Employee Health Insurance	67,622
Employee Meals	7,081
Illinois Municipal Retirement Fund (IMRF)*	
401K Contribution	3,319
Other Employee Benefits	12,611
TOTAL (agree to Schedule V, line 22, col.8)	$ 272,311

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,896
Advertising: Employee Recruitment	3,404
Health Care Worker Background Check	
(Indicate # of checks performed 82)	820
Patient Background Checks 310	3,102
Dues & Subscriptions	11,140
Licenses & Permits	1,652
Allocated from Generations Healthcare Netwo	91
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,105

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	9,399
Allocated from Generations Healthcare Netwo	227
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,626

* 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. $ **2,440** 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. $ **7,081** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ ____

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

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