FOR BHF USE

LL1

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

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

I. **IDPH License ID Number:** 0054239

Facility Name: Decatur Manor Healthcare

Address: 1016 W Pershing Road (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		

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/20 to 12/31/20 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)	05/21/2021 (Date)
	** Subject to the attached Accountants' Consulting Report*	
	(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**

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

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	1 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	53,802	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	147	TOTALS	147	53,802	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	47,767	290	581	48,638	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,767	290	581	48,638	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.40%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/2008

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/2008 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified ______ and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number: Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	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	204,595	33,948	38,844	277,387		277,387	(21,050)	256,337			1
2	Food Purchase		295,367		295,367		295,367	(3,659)	291,708			2
3	Housekeeping	169,562	34,970		204,532		204,532	(3,272)	201,260			3
4	Laundry	47,849	10,244		58,093		58,093	(248)	57,845			4
5	Heat and Other Utilities			120,118	120,118		120,118	(14,814)	105,304			5
6	Maintenance	65,150	16,691	127,134	208,975		208,975	(35,553)	173,422			6
7	Other (specify):*							2,817	2,817			7
8	**TOTAL General Services**	487,156	391,220	286,096	1,164,472		1,164,472	(75,780)	1,088,692			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	986,535	83,402	94,087	1,164,024		1,164,024	(47,843)	1,116,181			10
10a	Therapy											10a
11	Activities	60,849	14,692		75,541		75,541		75,541			11
12	Social Services	242,873		48,000	290,873		290,873		290,873			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							11,949	11,949			15
16	**TOTAL Health Care and Programs**	1,290,257	98,094	142,087	1,530,438		1,530,438	(35,894)	1,494,544			16
	C. General Administration											
17	Administrative	133,493		437,664	571,157		571,157	(294,981)	276,176			17
18	Directors Fees											18
19	Professional Services			402,762	402,762	(314)	402,448	(282,359)	120,090			19
20	Dues, Fees, Subscriptions & Promotions			68,993	68,993		68,993	(36,661)	32,332			20
21	Clerical & General Office Expenses	116,301	27,980	67,332	211,613		211,613	195,465	407,078			21
22	Employee Benefits & Payroll Taxes			343,471	343,471		343,471		343,471			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,016	3,016		3,016	(128)	2,888			24
25	Other Admin. Staff Transportation			4,596	4,596		4,596	6,589	11,185			25
26	Insurance-Prop.Liab.Malpractice			114,518	114,518		114,518	2,094	116,612			26
27	Other (specify):*							50,115	50,115			27
28	**TOTAL General Administration**	249,794	27,980	1,442,352	1,720,126	(314)	1,719,812	(359,865)	1,359,947			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,027,207	517,294	1,870,535	4,415,036	(314)	4,414,722	(471,539)	3,943,183			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			56,036	56,036		56,036	136,569	192,605			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,374	13,374		13,374	148,403	161,777			32
33	Real Estate Taxes					314	314	60,426	60,739			33
34	Rent-Facility & Grounds			552,000	552,000		552,000	(552,000)				34
35	Rent-Equipment & Vehicles			3,400	3,400		3,400	4,815	8,215			35
36	Other (specify):*											36
37	TOTAL Ownership			624,810	624,810	314	625,124	(201,787)	423,337			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)	2,027,207	517,294	2,495,345	5,039,846		5,039,846	(673,326)	4,366,520			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: 01/01/20 Ending: 12/31/20

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	(16,445)	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	(39,094)	30		9
10	Interest and Other Investment Income	(63,795)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(18)	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	(19,400)	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	(17,810)	21		24
25	Fund Raising, Advertising and Promotional	(7,609)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(11,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(102,258)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (277,429)		$	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)	(395,898)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (395,898)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (673,327)		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: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (50)	21	1
2	Prescription Drugs- VA	(22,143)	10	2
3	Bank Fees	(12,852)	21	3
4	Theft & Damage Loss	(456)	21	4
5	Vending & Cafe Income	(901)	02	5
6	Chamber of Commerce	(275)	20	6
7	Alliance Dues	(11,931)	20	7
8	Non Allowable Legal	(17,998)	19	8
9	Building Co Amortization Fees	(1,778)	36	9
10	Brokerage Fees	(2,960)	19	10
11	Building Co Office Expense	(4)	21	11
12	Building Co Filing Fees	(77)	20	12
13	Annual Report	(77)	20	13
14	Line of Credit Fees	(250)	20	14
15	Out of State Seminar	(495)	24	15
16	Capitalized R&M	(30,011)	06	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**	(102,258)		49

Detail lines 29 and 35 of Page 5 starting in C12. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 5B**

Decatur Manor Healthcare

ID# 0054239
Report Period Beginning: 01/01/20
Ending: 12/31/20

	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

Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Operating Expenses	PAGES 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				(20,860)		(190)						(21,050)	1
2	Food Purchase	(919)		(2,740)									(3,659)	2
3	Housekeeping						(3,272)						(3,272)	3
4	Laundry						(248)						(248)	4
5	Heat and Other Utilities	(16,445)			1,631								(14,814)	5
6	Maintenance	(30,011)		(6,853)	1,406		(95)						(35,553)	6
7	Other (specify):*			1,682	1,135								2,817	7
8	**TOTAL General Services**	(47,375)		(7,911)	(16,688)		(3,805)						(75,780)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(22,143)		(19,001)		(3,406)	(3,293)						(47,843)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			11,949									11,949	15
16	**TOTAL Health Care and Programs**	(22,143)		(7,052)		(3,406)	(3,293)						(35,894)	16
	C. General Administration													
17	Administrative			(417,349)	122,368								(294,981)	17
18	Directors Fees													18
19	Professional Services	(20,958)		(274,010)	12,609								(282,359)	19
20	Fees, Subscriptions & Promotions	(39,619)	77	2,881									(36,661)	20
21	Clerical & General Office Expenses	(42,172)	4	237,543	103	(13)							195,465	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(495)		367									(128)	24
25	Other Admin. Staff Transportation			6,589									6,589	25
26	Insurance-Prop.Liab.Malpractice			1,895	199								2,094	26
27	Other (specify):*			21,742	28,373								50,115	27
28	**TOTAL General Administration**	(103,243)	81	(420,342)	163,652	(13)							(359,865)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(172,761)	81	(435,305)	146,964	(3,420)	(7,098)						(471,539)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(39,094)	171,501		4,162								136,569	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(63,795)	210,808	(1,628)	3,019								148,403	32
33	Real Estate Taxes		53,190		7,236								60,426	33
34	Rent-Facility & Grounds		(552,000)										(552,000)	34
35	Rent-Equipment & Vehicles			4,815									4,815	35
36	Other (specify):*	(1,778)	1,778											36
37	**TOTAL Ownership**	(104,667)	(114,724)	3,187	14,417								(201,787)	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)**	(277,428)	(114,643)	(432,118)	161,381	(3,420)	(7,098)						(673,326)	45

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	$ 552,000	Decatur Healthcare Estates		$	$ (552,000)	1
2	V	20	Filing Fees		Decatur Healthcare Estates		77	77	2
3	V	32	Interest Expense		Decatur Healthcare Estates		210,808	210,808	3
4	V	21	Office Expense		Decatur Healthcare Estates		4	4	4
5	V	33	Real Estate Tax		Decatur Healthcare Estates		55,000	55,000	5
6	V	33	Real estate Tax Prior	1,810	Decatur Healthcare Estates			(1,810)	6
7	V	30	Depreciation Expense		Decatur Healthcare Estates		171,501	171,501	7
8	V	36	Amortization - Loan Fees		Decatur Healthcare Estates		1,778	1,778	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 553,810			$ 439,168	$ * (114,643)	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: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ATIED ASSOCIATES, LLC	26.39%	ALBANY CARE, INC.	EVANSTON	DECATUR HEALTHCARE ESTA	LINCOLNWOOD	BUILDING CO.	1
2	BARRISH GROUP LIMITED	8.80%	AUBURN VILLAGE	AUBURN, IN	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%	GENERATIONS AT APPLEWOOD, LLC	MATTESON	OAKTON ARMS	DES PLAINES	ASSISTED LIVING	4
5	JEFF ORAVEC	1.34%	GENERATIONS AT ELMWOOD PARK, INC	ELMWOOD PARK	MAC Rx LLC	DES PLAINES	PHARMACY	5
6	LOUISE BERGTHOLD	3.36%	GENERATIONS AT LINCOLN, LLC	LINCOLN	BIG TEN SUPPLY, LLC	LIBERTYVILLE	SUPPLY CO.	6
7	LYNN ETHELL	1.34%	GENERATIONS AT NEIGHBORS, LLC	BYRON	TRANSITIONS INDIANA	HUNTLEY	HOSPICE	7
8	NENITA GUZMAN	1.34%	GENERATIONS AT OAKTON PAVILION, LLC	DES PLAINES	GENERATIONS AT RIVERVIEW		ASSISTED & INDEPENDENT	8
9	PATRICIA MCDIARMID	1.34%	GENERATIONS AT PEORIA, LLC	PEORIA	SENIOR LIVING	EAST PEORIA	LIVING	9
10	RALPH GESUALDO	8.80%	GENERATIONS AT REGENCY, LLC	NILES				10
11	RALPH GESUALDO CHILDREN'S TRUST	8.80%	GENERATIONS AT RIVERVIEW, LLC	EAST PEORIA				11
12	RONALD NUNZIATO JR.	2.68%	GENERATIONS AT ROCK ISLAND, LLC	ROCK ISLAND				12
13	THOMAS & STEPHANIE WINTER REV. TRUST	6.71%	GREENWOOD CARE, INC.	EVANSTON				13
14	UNITED TRUST #1	4.40%	PRAIRIE CREEK VILLAGE, LLC	DECATUR				14
15	UNITED TRUST #2	4.40%	VILLA CLARA POST ACUTE, LLC	DECATUR				15
16	L.G. TRUST	4.39%	WILSON CARE, INC.	CHICAGO				16
17	B.G. TRUST	4.39%						17
18	KIM SHELTON	1.34%						18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

VII. RELATED PARTIES (continued)

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

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

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Dietary Other and Rebates	$	Generations HC Network, LLC		$ (2,740)	$ (2,740)	15
16	V	6	Repairs & Maintanence	20,196	Generations HC Network, LLC		13,343	(6,853)	16
17	V	7	Emp. Ben. - General Svc.		Generations HC Network, LLC		1,682	1,682	17
18	V	9	Medical Director Consults		Generations HC Network, LLC				18
19	V	10	Nursing	83,028	Generations HC Network, LLC		64,027	(19,001)	19
20	V	15	Emp. Ben. - Health Care		Generations HC Network, LLC		11,949	11,949	20
21	V	17	Administrative	437,664	Generations HC Network, LLC		20,315	(417,349)	21
22	V	19	Professional Fees	282,120	Generations HC Network, LLC		8,110	(274,010)	22
23	V	20	Fee, Subscriptions		Generations HC Network, LLC		2,881	2,881	23
24	V	21	Clerical & General	10,104	Generations HC Network, LLC		247,647	237,543	24
25	V	24	Education & Seminar		Generations HC Network, LLC		367	367	25
26	V	25	Other Admin. Staff Transportation		Generations HC Network, LLC		6,589	6,589	26
27	V	26	Insurance		Generations HC Network, LLC		1,895	1,895	27
28	V	27	Emp. Ben. - Gen. Admin.		Generations HC Network, LLC		21,742	21,742	28
29	V	32	Interest		Generations HC Network, LLC		(1,628)	(1,628)	29
30	V	35	Auto Rental		Generations HC Network, LLC		4,092	4,092	30
31	V	35	Equipment Rental		Generations HC Network, LLC		723	723	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 833,112			$ 400,994	$ * (432,118)	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: 01/01/20 Ending: 12/31/20

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	$ 26,928	Generations HC Network, LLC		$ 6,068	$ (20,860)	15
16	V	7	Emp. Ben. - Dietary		Generations HC Network, LLC		1,135	1,135	16
17	V	17	Admin./Legal Salaries		Generations HC Network, LLC		122,368	122,368	17
18	V	19	Fin. Consult./Regl. Dir.		Generations HC Network, LLC		12,211	12,211	18
19	V	27	Emp. Ben. - Administrative		Generations HC Network, LLC		28,373	28,373	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V	6	Maintenance Salaries		Generations HC Network, LLC				25
26	V	7	Employee Benefits		Generations HC Network, LLC				26
27	V								27
28	V	5	Utilities		Generations HC Network, LLC		1,631	1,631	28
29	V	6	Repairs & Maintenance		Generations HC Network, LLC		1,406	1,406	29
30	V	19	Professional Fees		Generations HC Network, LLC		398	398	30
31	V	21	Clerical & General		Generations HC Network, LLC		103	103	31
32	V	26	Insurance		Generations HC Network, LLC		199	199	32
33	V	30	Depreciation		Generations HC Network, LLC		4,162	4,162	33
34	V	32	Interest		Generations HC Network, LLC		3,019	3,019	34
35	V	33	Real Estate Taxes		Generations HC Network, LLC		7,236	7,236	35
36	V								36
37	V								37
38	V								38
39	Total			$ 26,928			$ 188,309	$ * 161,381	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: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	$ 36,449	MAC Rx, LLC		$ 33,043	$ (3,406)	15
16	V	21	Clerical & General Office Expenses	142	MAC Rx, LLC		129	(13)	16
17	V	22	Employee Benefits		MAC Rx, LLC				17
18	V	39	Ancillary		MAC Rx, LLC				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			$ 36,591			$ 33,172	$ * (3,420)	39

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

VII. RELATED PARTIES (continued)

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

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

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$ 1,975	Big Ten Supply, LLC		$ 1,786	$ (190)	15
16	V	3	Housekeeping	34,047	Big Ten Supply, LLC		30,774	(3,272)	16
17	V	4	Laundry	2,578	Big Ten Supply, LLC		2,330	(248)	17
18	V	6	Repairs & Maintenance	989	Big Ten Supply, LLC		894	(95)	18
19	V	10	Nursing And Medical Records	34,263	Big Ten Supply, LLC		30,970	(3,293)	19
20	V	10A	Therapy		Big Ten Supply, LLC				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			$ 73,853			$ 66,754	$ * (7,098)	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: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Bryan Barrish	Relative	Administrative	0.00%	See Attached	2.05	5.11%	Alloc. Salary	$ 14,612	17-7	1
2	Sarah Barrish	Relative	Administrative	0.00%	See Attached	2.92	5.84%	Alloc. Salary	7,513	17-7	2
3	Louise Bergthold	Shareholder	Administrative	3.36%	See Attached	3.51	5.84%	Alloc. Salary	14,612	17-7	3
4	Thomas Bergthold	Relative	Clerical	0.00%	See Attached	2.34	5.84%	Alloc. Salary	3,539	21-7	4
5	Clark Collins	Relative	Administrative	0.00%	See Attached	0.63	1.58%	Alloc. Salary	839	Various	5
6	Lynn Ethell	Shareholder	Clerical	1.34%	See Attached	2.34	5.84%	Alloc. Salary	3,521	21-7	6
7	Michael Giannini	Relative	Administrative	0.00%	See Attached	2.34	5.20%	Alloc. Salary	10,552	17-7	7
8	Nenita Guzman	Shareholder	Dietary	1.34%	See Attached	2.34	5.84%	Alloc. Salary	$ 6,068	1-7	8
9	Jeff Oravec	Shareholder	Administrative	1.34%	See Attached	2.34	5.84%	Alloc. Salary	5,703	17-7	9
10	See Supplemental Schedule								38,259		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	$ 105,218		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: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [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: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	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	2	Dietary Other and Rebates	Patient Days	832,144	19	$ (46,886)	$	48,638	$ (2,740)	1
2	6	Repairs & Maintanence	Patient Days	832,144	19	228,292	155,904	48,638	13,343	2
3	7	Emp. Ben. - General Svc.	Patient Days	832,144	19	28,781		48,638	1,682	3
4	9	Medical Director Consults	Patient Days	832,144	19			48,638		4
5	10	Nursing	Patient Days	832,144	19	1,095,433	1,094,370	48,638	64,027	5
6	15	Emp. Ben. - Health Care	Patient Days	832,144	19	204,429		48,638	11,949	6
7	17	Administrative	Patient Days	832,144	19	347,566	347,566	48,638	20,315	7
8	19	Professional Fees	Patient Days	832,144	19	138,762		48,638	8,110	8
9	20	Fee, Subscriptions	Patient Days	832,144	19	49,284		48,638	2,881	9
10	21	Clerical & General	Patient Days	832,144	19	4,236,976	3,850,828	48,638	247,647	10
11	24	Education & Seminar	Patient Days	832,144	19	6,287		48,638	367	11
12	25	Other Admin. Staff Transportatio	Patient Days	832,144	19	112,731		48,638	6,589	12
13	26	Insurance	Patient Days	832,144	19	32,419		48,638	1,895	13
14	27	Emp. Ben. - Gen. Admin.	Patient Days	832,144	19	371,977		48,638	21,742	14
15	32	Interest	Patient Days	832,144	19	(27,854)		48,638	(1,628)	15
16	35	Auto Rental	Patient Days	832,144	19	70,001		48,638	4,092	16
17	35	Equipment Rental	Patient Days	832,144	19	12,377		48,638	723	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 6,860,575	$ 5,448,668		$ 400,994	25

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary Salaries	Patient Days	832,144	19	$ 103,820	$ 103,820	48,638	$ 6,068	1
2	7	Emp. Ben. - Dietary	Patient Days	832,144	19	19,413		48,638	1,135	2
3	17	Admin./Legal Salaries	Patient Days	832,144	19	2,093,591	2,093,591	48,638	122,368	3
4	19	Fin. Consult./Regl. Dir.	Patient Days	832,144	19	208,920		48,638	12,211	4
5	27	Emp. Ben. - Administrative	Patient Days	832,144	19	485,424		48,638	28,373	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13	6	Maintenance Salaries	Maintenance Income	702,930	17	726,469	726,469			13
14	7	Employee Benefits	Maintenance Income	702,930	17	141,032				14
15										15
16	5	Utilities	Allocated Sq. Ft.	12,879	19	27,900		753	1,631	16
17	6	Repairs & Maintenance	Allocated Sq. Ft.	12,879	19	24,049		753	1,406	17
18	19	Professional Fees	Allocated Sq. Ft.	12,879	19	6,801		753	398	18
19	21	Clerical & General	Allocated Sq. Ft.	12,879	19	1,754		753	103	19
20	26	Insurance	Allocated Sq. Ft.	12,879	19	3,403		753	199	20
21	30	Depreciation	Allocated Sq. Ft.	12,879	19	71,181		753	4,162	21
22	32	Interest	Allocated Sq. Ft.	12,879	19	51,631		753	3,019	22
23	33	Real Estate Taxes	Allocated Sq. Ft.	12,879	19	123,763		753	7,236	23
24										24
25	TOTALS					$ 4,089,151	$ 2,923,880		$ 188,309	25

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES 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	10	Nursing And Medical Records	Direct Allocation			$	$		$ 33,043	1
2	21	Clerical & General Office Expense	Direct Allocation						129	2
3	22	Employee Benefits	Direct Allocation							3
4	39	Ancillary	Direct Allocation							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					$	$		$ 33,172	25

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	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			$	$		$ 1,786	1
2	3	Housekeeping	Direct Allocation						30,774	2
3	4	Laundry	Direct Allocation						2,330	3
4	6	Repairs & Maintenance	Direct Allocation						894	4
5	10	Nursing And Medical Records	Direct Allocation						30,970	5
6	10A	Therapy	Direct Allocation							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					$	$		$ 66,754	25

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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: 01/01/20 Ending: 12/31/20

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	First Source		X	Vehicle			$	$ 15,844			$ 985	1
2	Midland State Bank		X	Mortgage			$	$ 3,597,910			$ 210,841	2
3							$	$			$	3
4							$	$			$	4
5							$	$			$	5
	Working Capital											
6	Lake Forest Bank & Trust		X	Line of Credit				-			10,995	6
7	IL Dept of HFS		X					-			1,395	7
8												8
9	TOTAL Facility Related						$	$ 3,613,755			$ 224,216	9
	B. Non-Facility Related*											
10	Interest Income		X								(63,795)	10
11	Interest Income - Building Co		X								(33)	11
12	Allocated from Generations HC		X								1,391	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (62,438)	14
15	TOTALS (line 9+line14)						$	$ 3,613,755			$ 161,778	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: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Item		Amount	Line
1. Real Estate Tax accrual used on 2019 report.	$	54,615	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	60,043	2
3. Under or (over) accrual (line 2 minus line 1).	$	5,428	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	$	55,000	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.)**	$	314	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.	$	60,742	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Year	Amount	Line
	2015	50,791	8
	2016	53,206	9
	2017	52,691	10
	2018	52,515	11
	2019	52,807	12

2020 Accrual - $52,807 x 1.04 = $55,000

Allocated from Generations HC Network: $7,236

Line	FOR BHF USE ONLY			Line
13	FROM R. E. TAX STATEMENT FOR 2019	$		13
14	PLUS APPEAL COST FROM LINE 5	$		14
15	LESS REFUND FROM LINE 6	$		15
16	AMOUNT TO USE FOR RATE CALCULATION	$		16

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Decatur Manor Healthcare COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0054239

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

	(A) 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	$ 52,806.54	$ 52,806.54
2.	10-31-401-046-0000	Home Office Allocation	$ 796,746.36	$ 565.99
3.	See Attached	Home Office Allocation	$ 148,905.51	$ 6,818.23
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 998,458	$ 60,191

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2019 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

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

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Decatur Manor Healthcare COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0054239

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

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

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

	(A) 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 X NO

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

C. **Tax Bills**

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

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

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	130,680	2008	$ 100,000	1
2					2
3	TOTALS	130,680		$ 100,000	3

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 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	$ 171,501	35	$ 82,939	$ (88,562)	$ 1,066,599	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2008	11,477		20			11,477	9
10	Various			2009	26,920		20	1,346	1,346	15,406	10
11	Various			2010	26,169		20	1,028	1,028	20,997	11
12	Various			2011	117,148		20	5,858	5,858	54,464	12
13	Various			2012	253,113		20	12,655	12,655	109,079	13
14	Various			2013	36,564		20	1,828	1,828	13,774	14
15	Various			2014	54,289		20	2,715	2,715	19,111	15
16	Various			2015	40,209		20	2,011	2,011	11,045	16
17	Various			2016	24,172		20	1,208	1,208	5,686	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: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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)		841,316			42,378	42,378	482,643	67
68	Related Party Allocations (Pages 12H & 12I)		121,856	2,331		3,678	1,348	75,120	68
69	Financial Statement Depreciation			56,036			(56,036)		69
70	TOTAL (lines 4 thru 69)		$ 4,456,108	$ 229,868		$ 157,644	$ (72,223)	$ 1,885,400	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: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,456,108	$ 229,868		$ 157,644	$ (72,223)	$ 1,885,400	1
2	Furnace For E-Wing	2017	5,265		20	263	263	1,031	2
3	Front Door Alarm	2017	4,064		20	203	203	745	3
4	Furnace For G-Wing	2017	5,699		20	285	285	879	4
5	Hvac Repairs	2017	2,522		20	126	126	473	5
6	Remove Ceiling In Room And Bathroom/Light Fixtures/Paint	2018	3,415		20	171	171	513	6
7	Installed Drywall On Walls & Ceiling	2018	3,680		20	184	184	460	7
8	Tree Removal & Replacement	2018	8,147		20	407	407	916	8
9	New Phone System Impr	2019	9,461		20	473	473	788	9
10	Hall E1 & Hall D1 New Condensers Hvac	2019	8,532		20	427	427	676	10
11	Roof Top Ac Compressor	2019	3,206		20	160	160	254	11
12	New Shingles On East Section Of Roof	2019	8,860		20	443	443	628	12
13	65' Concrete Side Walk	2019	3,880		20	194	194	226	13
14	45' Concrete Side Walk	2019	2,880		20	144	144	168	14
15	Dynalock Egress System (Door Lock)	2019	3,054		20	153	153	229	15
16	Replace Radiator On Generator	2020	2,589		20	129	129	129	16
17	Roofing On Eastside Of N/W Section	2020	10,800		20	540	540	540	17
18	147 Privacy Curtains	2020	30,011		20	1,501	1,501	1,501	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)		$ 4,572,173	$ 229,868		$ 163,447	$ (66,420)	$ 1,895,557	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: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,572,173	$ 229,868		$ 163,447	$ (66,420)	$ 1,895,557	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,572,173	$ 229,868		$ 163,447	$ (66,420)	$ 1,895,557	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: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,572,173	$ 229,868		$ 163,447	$ (66,420)	$ 1,895,557	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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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,572,173	$ 229,868		$ 163,447	$ (66,420)	$ 1,895,557	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: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 4,572,173	$ 229,868		$ 163,447	$ (66,420)	$ 1,895,557	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,572,173	$ 229,868		$ 163,447	$ (66,420)	$ 1,895,557	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: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	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	54,041	9
10	Hand Rails	2008	41,519		20	2,076	2,076	26,988	10
11	Demolition, Framing, Plumbing, Heating…	2008	71,200		20	3,560	3,560	46,280	11
12	Demolition, Electrical, Plumbing, Painting, Flooring	2008	455,946		20	22,797	22,797	296,361	12
13	Painting Doors	2008	7,840		20	392	392	5,096	13
14	Draperies	2008	35,206		20	1,760	1,760	8,250	14
15	Trane A/C Unit	2010	12,989		20	649	649	7,139	15
16	Fire Alarm	2010	7,539		20	377	377	4,147	16
17	Rooftop Heat Exchanger	2010	9,900		20	495	495	5,445	17
18	Satelite TV Install	2010	11,930		20	909	909	9,999	18
19	Paving Parking Lot	2010	12,000		20	600	600	6,600	19
20	Basketball Court	2018	14,482		20	724	724	2,172	20
21	HVAC Condenser	2018	3,844		20	192	192	576	21
22	Patio Construction	2018	9,099		20	455	455	1,365	22
23	Breakroom Remodel	2018	2,935		20	147	147	441	23
24	HVAC Replacement	2018	12,110		20	606	606	1,817	24
25	Furnace Condenser & Coils	2018	19,240		20	962	962	2,886	25
26	108 Roller Shades with Facia	2018	30,396		20	1,520	1,520	3,040	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 841,316	$		$ 42,378	$ 42,378	$ 482,643	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: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 841,316	$		$ 42,378	$ 42,378	$ 482,643	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 841,316	$		$ 42,378	$ 42,378	$ 482,643	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: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Generations Healthcare Network, LLC	2009	29,234	780	39	750	(31)	8,277	3
4	Allocated from S.I.R. Properties/GHN	1993	26,466	840	35	756	(84)	20,038	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Generations Healthcare Network, LLC	1993	6,710	187	20		(187)	6,710	9
10	Allocated from Generations Healthcare Network, LLC	1994	21		20			21	10
11	Allocated from Generations Healthcare Network, LLC	1995	153		20			153	11
12	Allocated from Generations Healthcare Network, LLC	1997	10,310	231	20		(231)	10,310	12
13	Allocated from Generations Healthcare Network, LLC	1999	811		20	31	31	811	13
14	Allocated from Generations Healthcare Network, LLC	1999							14
15	Allocated from Generations Healthcare Network, LLC	2000	957		20	22	22	957	15
16	Allocated from Generations Healthcare Network, LLC	2007	3,075		20	154	154	2,029	16
17	Allocated from Generations Healthcare Network, LLC	2008	8,475		20	313	313	6,199	17
18	Allocated from Generations Healthcare Network, LLC	2009	21,060		20	1,053	1,053	11,841	18
19	Allocated from Generations Healthcare Network, LLC	2011	521	52	20	52		491	19
20	Allocated from Generations Healthcare Network, LLC	2012	1,667	83	20	83		618	20
21	Allocated from Generations Healthcare Network, LLC	2014	234	23	20	12	(12)	77	21
22	Allocated from Generations Healthcare Network, LLC	2016	304	15	20	15		67	22
23	Allocated from Generations Healthcare Network, LLC	2019	1,517	75	20	75		95	23
24	Allocated from Generations Healthcare Network, LLC	2020	1,236	26	20	26	0	26	24
25									25
26	Allocated from S.I.R. Properties/GHN	2012	1,621		20	81	81	568	26
27	Allocated from S.I.R. Properties/GHN	2010	1,597		20	80	80	745	27
28	Allocated from S.I.R. Properties/GHN	2009	1,589		20	79	79	858	28
29	Allocated from S.I.R. Properties/GHN	2007	157	9	20	8	(1)	102	29
30	Allocated from S.I.R. Properties/GHN	2002	105		20	5	5	92	30
31	Allocated from S.I.R. Properties/GHN	1999	3,354		20	84	84	3,354	31
32	Allocated from S.I.R. Properties/GHN	1994	252	6	20		(6)	252	32
33	Allocated from S.I.R. Properties/GHN	1993	429	2	20		(2)	429	33
34	TOTAL (lines 1 thru 33)		$ 121,856	$ 2,331		$ 3,678	$ 1,348	$ 75,120	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: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 121,856	$ 2,331		$ 3,678	$ 1,348	$ 75,120	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 121,856	$ 2,331		$ 3,678	$ 1,348	$ 75,120	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: 01/01/20 Ending: 12/31/20

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	$ 185,889	$ 1,240	$ 18,606	$ 17,366	10	$ 125,170	71
72	Current Year Purchases	246	16	16		10	16	72
73	Fully Depreciated Assets	1,105,296				10	1,105,296	73
74								74
75	TOTALS	$ 1,291,431	$ 1,256	$ 18,622	$ 17,366		$ 1,230,481	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		2019 Ford Escape S	2019	$ 20,899	$	$ 4,180	$ 4,180	5	$ 7,315	76
77		12 - Passenger Van	2020	26,571		5,314	5,314	5	5,314	77
78										78
79		See Attached		6,894	575	1,041	466		3,694	79
80	TOTALS			$ 54,364	$ 575	$ 10,535	$ 9,960		$ 16,323	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)	$ 6,017,968	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 231,699	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 192,604	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (39,094)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,142,361	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		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	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: 01/01/20 Ending: 12/31/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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	Storage Rental							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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 4,123 Description: See Attached
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Generatio		$	$ 4,092	17
18					18
19					19
20					20
21	TOTAL		$	$ 4,092	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: 01/01/20 Ending: 12/31/20

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 Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
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.

Facility Name & ID Number Decatur Manor Healthcare # 0054239 Report Period Beginning: 01/01/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (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	$ 414,650	$ 605,701	1
2	Cash-Patient Deposits	33,846	33,846	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	571,232	571,232	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,179	18,179	6
7	Other Prepaid Expenses	193,747	193,747	7
8	Accounts Receivable (owners or related parties)	3,050,000	3,050,000	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,281,654	$ 4,472,705	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	469,951	1,203,307	15
16	Equipment, at Historical Cost	361,516	1,440,799	16
17	Accumulated Depreciation (book methods)	(500,960)	(2,985,019)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):		1,457,035	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 330,507	$ 4,118,997	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,612,161	$ 8,591,702	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 492,909	$ 492,910	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,865	33,865	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	82,534	82,534	30
31	Accrued Taxes Payable (excluding real estate taxes)	99,071	99,071	31
32	Accrued Real Estate Taxes(Sch.IX-B)		55,000	32
33	Accrued Interest Payable		7,276	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		946,035	946,035	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,654,414	$ 1,716,691	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	15,844	15,844	39
40	Mortgage Payable		3,597,910	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43			63,786	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 15,844	$ 3,677,540	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,670,258	$ 5,394,231	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,941,903	$ 3,197,471	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,612,161	$ 8,591,702	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,216,084	1
2	Restatements (describe):		2
3	Rounding	3	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,216,087	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,088,216	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	(362,400)	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)**	$ 725,816	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)**	$ 2,941,903	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	$ 5,853,230	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,853,230	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	17,707	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)**	$ 17,707	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	63,795	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 63,795	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28		193,330	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 193,330	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,128,062	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,164,472	31
32	Health Care	1,530,438	32
33	General Administration	1,720,126	33
	B. Capital Expense		
34	Ownership	624,810	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)***	$ 5,039,846	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,088,216	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,088,216	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 790,522	44
45	Private Pay - Net Inpatient Revenue	67,750	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) **Managed Care**	4,918,952	47
48	Other-(specify) **Veterans**	76,006	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,853,230	49

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

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

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

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

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,788	2,053	$ 84,074	$ 40.95	1
2	Assistant Director of Nursing	1,847	2,077	69,867	33.64	2
3	Registered Nurses	2,436	2,546	73,957	29.05	3
4	Licensed Practical Nurses	11,317	11,860	311,445	26.26	4
5	CNAs & Orderlies	36,231	38,109	425,868	11.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,006	5,508	60,849	11.05	10
11	Social Service Workers	13,051	13,884	242,873	17.49	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,688	18,228	204,595	11.22	15
16	Dishwashers					16
17	Maintenance Workers	3,650	3,963	65,150	16.44	17
18	Housekeepers	12,820	13,504	169,562	12.56	18
19	Laundry	4,061	4,532	47,849	10.56	19
20	Administrator	1,878	2,106	133,493	63.39	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,725	3,893	50,929	13.08	23
24	Clerical	3,363	3,517	65,372	18.59	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	1,698	1,837	21,324	11.61	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	120,559	127,617	$ 2,027,207 *	$ 15.89	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 38,844	01-03	35
36	Medical Director				36
37	Medical Records Consultant	Monthly	440	10-03	37
38	Nurse Consultant	Monthly	83,028	10-03	38
39	Pharmacist Consultant	Monthly	10,619	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				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Pysch Medical Director	Monthly	48,000	12-03	47
48					48
49	TOTAL (lines 35 - 48)		$ 180,931		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	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

STATE OF ILLINOIS

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ruth Huber	Adminstrator		$ 133,493
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 133,493

B. Administrative - Other

Description	Amount
Generations Healthcare Network - Dir. Of Admin. Services	$ 78,540
Generations Healthcare Network - Ancillary Admin. Services	67,320
Generations Healthcare Network - Consulting Fees	291,804
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 437,664

C. Professional Services

Vendor/Payee	Type	Amount
Generations Healthcare Network	Dir. of Financial Services	$ 52,740
Generations Healthcare Network	Dir. of Business Development	60,588
Generations Healthcare Network	Dir. of Regulatory Services	26,928
Generations Healthcare Network	Dir. of Information Technology	13,464
Generations Healthcare Network	Bookkeeping Services	128,400
Generations Healthcare Network	Computer Support Charges	35,904
Marcum LLP	Accounting Fees	20,750
Plante Moran	Accounting Fees	800
Paylocity	Payroll Processing	8,943
Paychex	Payroll Processing	198
See Attached	Legal	25,892
See Supplemental Schedule		28,156
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 402,762

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 24,267
Unemployment Compensation Insurance	14,646
FICA Taxes	155,081
Employee Health Insurance	110,442
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	2,190
Employee Benefits - Other	36,845
TOTAL (agree to Schedule V, line 22, col.8)	$ 343,471

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 4,361
Advertising: Employee Recruitment	9,858
Health Care Worker Background Check	
(Indicate # of checks performed 78)	780
Patient Background Checks 122	1,218
Dues & Subscriptions	7,412
Licenses & Fees	5,822
See Supplemental Schedule	2,881
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,332

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,521
See Supplemental Schedule	367
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,888

**See instructions.

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XX. GENERAL INFORMATION:

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

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

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,247** Line **10-02**

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

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

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ ____
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. $ ____ 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? **No**
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.