FOR BHF USE

LL1

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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: 0049262

Facility Name: Decatur Manor Healthcare

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

County: Macon

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/14 to 12/31/14 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Cary Drazner, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED	40,860	1,046	3,528	45,434	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,860	1,046	3,528	45,434	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.68%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold 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 [No]

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

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

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	181,516	23,998	28,633	234,147		234,147	(13,186)	220,961			1
2	Food Purchase		249,184		249,184	(6,497)	242,687	(1,429)	241,258			2
3	Housekeeping	138,626	29,770		168,396		168,396		168,396			3
4	Laundry	33,509	11,306		44,815		44,815		44,815			4
5	Heat and Other Utilities			97,560	97,560		97,560	(7,880)	89,680			5
6	Maintenance	55,482	28,129	151,694	235,305		235,305	(25,436)	209,869			6
7	Other (specify):*							2,820	2,820			7
8	TOTAL General Services	409,133	342,387	277,887	1,029,407	(6,497)	1,022,910	(45,111)	977,799			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	989,126	80,455	94,641	1,164,222		1,164,222	(53,236)	1,110,986			10
10a	Therapy			17,640	17,640		17,640	(9,061)	8,579			10a
11	Activities	65,611	14,637	902	81,150		81,150		81,150			11
12	Social Services	150,696			150,696		150,696		150,696			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							4,873	4,873			15
16	TOTAL Health Care and Programs	1,205,433	95,092	131,183	1,431,708		1,431,708	(57,424)	1,374,284			16
	C. General Administration											
17	Administrative	98,017		274,826	372,843		372,843	(227,286)	145,557			17
18	Directors Fees											18
19	Professional Services			169,818	169,818	(534)	169,284	(89,099)	80,184			19
20	Dues, Fees, Subscriptions & Promotions			52,228	52,228		52,228	(26,883)	25,345			20
21	Clerical & General Office Expenses	109,014	21,765	83,973	214,752		214,752	62,645	277,397			21
22	Employee Benefits & Payroll Taxes			284,174	284,174	6,497	290,671		290,671			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,888	4,888		4,888	626	5,514			24
25	Other Admin. Staff Transportation			13,550	13,550		13,550	(4,232)	9,318			25
26	Insurance-Prop.Liab.Malpractice			102,393	102,393		102,393	1,730	104,123			26
27	Other (specify):*							32,002	32,002			27
28	TOTAL General Administration	207,031	21,765	985,850	1,214,646	5,963	1,220,609	(250,497)	970,112			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,821,597	459,244	1,394,920	3,675,761	(534)	3,675,227	(353,032)	3,322,194			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Decatur Manor Healthcare #0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			46,546	46,546		46,546	223,949	270,495			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,399	2,399		2,399	182,867	185,266			32
33	Real Estate Taxes					534	534	52,953	53,487			33
34	Rent-Facility & Grounds			408,000	408,000		408,000	(408,000)				34
35	Rent-Equipment & Vehicles			7,591	7,591		7,591	4,953	12,544			35
36	Other (specify):*											36
37	**TOTAL Ownership**			464,536	464,536	534	465,070	56,722	521,793			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		539		539		539		539			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**		539		539		539		539			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,821,597	459,783	1,859,456	4,140,836		4,140,836	(296,310)	3,844,526			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 # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	(9,403)	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	18,000	30		9
10	Interest and Other Investment Income	(30,000)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(57)	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	(15,489)	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	(4,281)	21		24
25	Fund Raising, Advertising and Promotional	(5,829)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(144,943)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (192,002)		$	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)	(104,308)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (104,308)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (296,310)		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

STATE OF ILLINOIS **Page 5A**

Decatur Manor Healthcare

ID# **0049262**

Report Period Beginning: **01/01/14**

Ending: **12/31/14**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Veterans Prescritption Drugs	$ (43,316)	10	1
2	Bank Fees	(6,530)	21	2
3	Theft & Damage	(180)	21	3
4	Misc Income	(53)	21	4
5	State Replaement Tax	(7,500)	21	5
6	Dues & Subscriptions - PAC	(7,798)	20	6
7	Capitalized R&M	(27,333)	06	7
8	Building Co. - Amortization	(1,456)	36	8
9	Building Co. - Filing Fees	(250)	21	9
10	Building Co. - Office Expenses	(101)	21	10
11	Non Allowable Legal	(341)	19	11
12	Building Co. -Professional Fees	(43,402)	19	12
13	Vending Income	(1,372)	02	13
14	Additional R & M	6,689	06	14
15	Non Allowable Travel	(12,000)	25	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(144,943)		49

Decatur Manor Healthcare

ID# 0049262

Report Period Beginning: 01/01/14

Ending: 12/31/14

	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**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Decatur Manor Healthcare # 0049262 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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				(13,186)								(13,186)	1
2	Food Purchase	(1,429)											(1,429)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(9,403)			1,523								(7,880)	5
6	Maintenance	(20,644)		(9,143)	4,351								(25,436)	6
7	Other (specify):*			533	2,287								2,820	7
8	**TOTAL General Services**	(31,476)		(8,610)	(5,025)								(45,111)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(43,316)		(16,083)	6,163								(53,236)	10
10a	Therapy				(9,061)								(9,061)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			2,714	2,159								4,873	15
16	**TOTAL Health Care and Programs**	(43,316)		(13,369)	(739)								(57,424)	16
	C. General Administration													
17	Administrative			(289,624)	62,338								(227,286)	17
18	Directors Fees													18
19	Professional Services	(43,743)	43,402	(101,256)	12,498								(89,099)	19
20	Fees, Subscriptions & Promotions	(29,116)		2,233									(26,883)	20
21	Clerical & General Office Expenses	(18,895)	351	81,134	55								62,645	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			626									626	24
25	Other Admin. Staff Transportation	(12,000)		7,768									(4,232)	25
26	Insurance-Prop.Liab.Malpractice			1,621	109								1,730	26
27	Other (specify):*			19,130	12,872								32,002	27
28	**TOTAL General Administration**	(103,754)	43,753	(278,368)	87,872								(250,497)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(178,546)	43,753	(300,347)	82,108								(353,032)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Decatur Manor Healthcare # 0049262 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	18,000	201,515		4,434								223,949	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(30,000)	223,492	(15,448)	4,823								182,867	32
33	Real Estate Taxes		47,140		5,813								52,953	33
34	Rent-Facility & Grounds		(408,000)										(408,000)	34
35	Rent-Equipment & Vehicles			4,953									4,953	35
36	Other (specify):*	(1,456)	1,456											36
37	TOTAL Ownership	(13,456)	65,603	(10,495)	15,070								56,722	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)	(192,002)	109,356	(310,842)	97,178								(296,310)	45

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 408,000	Decatur Healthcare Estates	100.00%	$	$ (408,000)	1
2	V	36	Amortization-Loan Fees		Decatur Healthcare Estates	100.00%	1,456	1,456	2
3	V	30	Depreciation		Decatur Healthcare Estates	100.00%	201,515	201,515	3
4	V	21	Filing Fees		Decatur Healthcare Estates	100.00%	250	250	4
5	V	32	Interest Expense		Decatur Healthcare Estates	100.00%	223,567	223,567	5
6	V	21	Office		Decatur Healthcare Estates	100.00%	101	101	6
7	V	19	Professional Fees		Decatur Healthcare Estates	100.00%	43,402	43,402	7
8	V	33	Real Estate Taxes	1,460	Decatur Healthcare Estates	100.00%	48,600	47,140	8
9	V	32	Interest Income	75	Decatur Healthcare Estates	100.00%		(75)	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 409,535			$ 518,891	$ * 109,356	14

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

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS AND MAINT.	$ 17,640	S.I.R. MANAGEMENT, INC.	100.00%	$ 8,497	$ (9,143)	15
16	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	533	533	16
17	V	10	NURSING	35,280	S.I.R. MANAGEMENT, INC.	100.00%	19,197	(16,083)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	2,714	2,714	18
19	V	19	PROFESSIONAL FEES	111,852	S.I.R. MANAGEMENT, INC.	100.00%	8,048	(103,804)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	2,233	2,233	20
21	V	21	CLERICAL & GENERAL	35,280	S.I.R. MANAGEMENT, INC.	100.00%	35,757	477	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	626	626	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	7,768	7,768	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,621	1,621	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	5,639	5,639	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(15,448)	(15,448)	26
27	V	35	AUTO RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	4,120	4,120	27
28	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	833	833	28
29	V								29
30	V	17	ADMINISTRATIVE	310,106	S.I.R. MANAGEMENT, INC.	100.00%	20,482	(289,624)	30
31	V	19	PROFESSIONAL FEES	2,900	S.I.R. MANAGEMENT, INC.	100.00%	5,448	2,548	31
32	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	80,657	80,657	32
33	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	13,491	13,491	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 513,058			$ 202,216	$ * (310,842)	39

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

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 17,640	S.I.R. MANAGEMENT, INC.	100.00%	$ 4,454	$ (13,186)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	657	657	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	6,163	6,163	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	878	878	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	62,338	62,338	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	11,907	11,907	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	12,872	12,872	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	17,640	S.I.R. MANAGEMENT, INC.	100.00%	8,579	(9,061)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,281	1,281	25
26	V								26
27	V	6	MAINTENANCE SALARIES	7,268	S.I.R. MANAGEMENT, INC.	100.00%	10,423	3,155	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,630	1,630	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	1,523	1,523	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	1,196	1,196	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	591	591	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	55	55	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	109	109	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	4,434	4,434	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	4,823	4,823	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	5,813	5,813	37
38	V								38
39	Total			$ 42,548			$ 139,726	$ * 97,178	39

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

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	26.390%	ALBANY CARE INC	EVANSTON	DECATUR HEALTHCARE ESTA	LINCOLNWOOD	BUILDING CO.	1
2	BARRISH GROUP LIMITED	8.799%	APPLEWOOD REHABILITATION CENTER,LLC	MATTESON	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	2
3	BRYAN BARRISH TRUST	8.799%	BRYN MAWR CARE INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	FAY CHIN	1.340%	COLUMBUS PARK NURSING & REHABILITATION CENTER, INC.	CHICAGO	OAKTON ARMS	DES PLAINES	ASSISTED LIVING	4
5	JEFF ORAVEC	1.340%	ELMWOOD CARE, INC.	ELMWOOD PARK				5
6	LOUISE BERGTHOLD	3.355%	OAKTON PAVILION	DES PLAINES				6
7	LYNN ETHELL	1.340%	GREENWOOD CARE, INC.	EVANSTON				7
8	NENITA GUZMAN	1.340%	WESLEY REHABILITATION CENTER	AUBURN, IN				8
9	PATRICIA MCDIARMID	1.340%	NEIGHBORS REHABILITATION CENTER,LLC	BYRON				9
10	RALPH GESUALDO	8.799%	REGENCY REHABILITATION CENTER,LLC	NILES				10
11	RALPH GESUALDO CHILDREN'S TRUST	8.799%	ROCK ISLAND NURSING & REHAB CENTER,LLC	ROCK ISLAND				11
12	RONALD NUNZIATO JR.	2.670%	WILSON CARE, INC.	CHICAGO				12
13	THOMAS WINTER	6.711%						13
14	UNITED TRUST #1	4.399%						14
15	UNITED TRUST #2	4.399%						15
16	L.G. TRUST	4.390%						16
17	B.G. TRUST	4.390%						17
18	KIM SHELTON	1.342%						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 # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Tom Winter	Shareholder	Administrative	6.71%	See Attached	3.63	6.05%	Alloc. Salary	$ 12,091	17-07	1
2	Louise Bergthold	Shareholder	Administrative	3.36%	See Attached	3.63	6.05%	Alloc. Salary	12,091	17-07	2
3	Patricia Mediarmid	Shareholder	Administrative	1.34%	See Attached	3.02	6.04%	Alloc. Salary	9,538	17-07	3
4	Andrew Chin	Relative	Clerical		See Attached	2.42	6.05%	Alloc. Salary	4,531	21-07	4
5	Jeff Oraveec	Shareholder	Administrative	1.34%	See Attached	2.42	6.05%	Alloc. Salary	8,391	17-07	5
6	Fay Chin	Shareholder	Nursing	1.34%	See Attached	2.42	6.05%	Alloc. Salary	6,163	10-07	6
7	Nenita Guzman	Shareholder	Dietary	1.34%	See Attached	3.02	6.04%	Alloc. Salary	4,454	01-07	7
8	Kim Shelton	Shareholder	Clerical	1.34%	See Attached	2.42	6.05%	Alloc. Salary	4,258	21-07	8
9											9
10	See Supplemental Schedule								37,556		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	$ 99,073		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 # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	REPAIRS AND MAINT.	PATIENT DAYS	751,530	16	$ 140,542	$ 58,090	45,434	$ 8,497	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	751,530	16	8,819		45,434	533	2
3	10	NURSING	PATIENT DAYS	751,530	16	317,539	317,539	45,434	19,197	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	751,530	16	44,898		45,434	2,714	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	751,530	16	133,120	89,849	45,434	8,048	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	751,530	16	36,940		45,434	2,233	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	751,530	16	591,459	531,411	45,434	35,757	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	751,530	16	10,362		45,434	626	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	751,530	16	128,491		45,434	7,768	9
10	26	INSURANCE	PATIENT DAYS	751,530	16	26,818		45,434	1,621	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	751,530	16	93,282		45,434	5,639	11
12	32	INTEREST	PATIENT DAYS	751,530	16	(255,531)		45,434	(15,448)	12
13	35	AUTO RENTAL	PATIENT DAYS	751,530	16	68,150		45,434	4,120	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	751,530	16	13,772		45,434	833	14
15										15
16	17	ADMINISTRATIVE	PATIENT DAYS	751,530	16	338,802	338,802	45,434	20,482	16
17	19	PROFESSIONAL FEES	PATIENT DAYS	751,530	16	90,119		45,434	5,448	17
18	21	CLERICAL & GENERAL	PATIENT DAYS	751,530	16	1,334,152	1,203,304	45,434	80,657	18
19	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	751,530	16	223,152		45,434	13,491	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,344,886	$ 2,538,995		$ 202,216	25

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	751,530	16	$ 73,669	$ 73,669	45,434	$ 4,454	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	751,530	16	10,866		45,434	657	2
3	10	NURSING SALARIES	PATIENT DAYS	751,530	16	101,941	101,941	45,434	6,163	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	751,530	16	14,528		45,434	878	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	751,530	16	1,031,137	1,031,137	45,434	62,338	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	751,530	16	196,950		45,434	11,907	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	751,530	16	212,914		45,434	12,872	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	274,680	15	133,582	133,582	17,640	8,579	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	274,680	15	19,951		17,640	1,281	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	395,144	15	566,698	566,698	7,268	10,423	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	395,144	15	88,633		7,268	1,630	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,880	15	25,179		779	1,523	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,880	15	19,781		779	1,196	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,880	15	9,777		779	591	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,880	15	907		779	55	19
20	26	INSURANCE	ALLOCATED SQ FT	12,880	15	1,804		779	109	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,880	15	73,312		779	4,434	21
22	32	INTEREST	ALLOCATED SQ FT	12,880	15	79,739		779	4,823	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,880	15	96,114		779	5,813	23
24										24
25	TOTALS					$ 2,757,482	$ 1,907,027		$ 139,726	25

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Centure Bank		X	Mortgage			$	$ 3,583,283			$ 223,567	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Lake Forest Bank & Trust		X	Line of Credit		04/02/2008		450,000		0.0500	2,399	6
7	Hyundai Finance		X	Note Payable	$299.45	08/26/2010	16,300	2,361	08/26/2015	3.9000		7
8	See Supplemental Schedule										4,823	8
9	TOTAL Facility Related				$299.45		$ 16,300	$ 4,035,644			$ 230,789	9
	B. Non-Facility Related*											
10	Interst Income		X								(30,000)	10
11	Interest Income - Bldg CO		X								(75)	11
12	Alloc from SIR Mngmnt	X									(15,448)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (45,523)	14
15	TOTALS (line 9+line14)						$ 16,300	$ 4,035,644			$ 185,266	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 # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9	Allocated from S.I.R. Mngmnt	X									4,823	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										4,823	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

** 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 # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 48,160	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.)		$ 52,513	2
3. Under or (over) accrual (line 2 minus line 1).		$ 4,353	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 48,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ 534	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.		$ 53,487	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	74,716	8
	2010	75,972	9
	2011	60,024	10
	2012	46,308	11
	2013	46,700	12

2014 Accrual - $46,700 x 1.04 = $48,568
Allocated from S.I.R. Managment -$5,813

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Decatur Manor Healthcare COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0049262

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(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	$ 46,699.68	$ 46,699.68
2.	See Attached	Home Office Allocation	$ 116,016.54	$ 5,495.28
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 162,716.22	$ 52,194.96

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. 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 Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Decatur Manor Healthcare COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0049262

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

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

Enter the tax index number and real estate tax assessed for 2000 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 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$

4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 95,605	35	$ 82,939	$ (12,666)	$ 568,965	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2008	11,477		20	1,148	1,148	7,591	9
10	Various			2009	26,920		20	1,346	1,346	7,331	10
11	Various			2010	26,169		20	2,628	2,628	11,972	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*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 # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		749,210	43,387		37,772	(5,615)	194,080	67
68	Related Party Allocations (Pages 12H & 12I)		109,850	2,966		4,207	1,241	53,707	68
69	Financial Statement Depreciation			46,546			(46,546)		69
70	TOTAL (lines 4 thru 69)		$ 3,826,501	$ 188,504		$ 130,039	$ (58,465)	$ 843,646	70

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

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 3,826,501	$ 188,504		$ 130,039	$ (58,465)	$ 843,646	1
2	Hvac- Air Unit	2011	5,545		20	555	555	1,941	2
3	Security Camera System	2011	9,845		20	492	492	1,600	3
4	Power Generator	2011	54,850		20	2,743	2,743	8,685	4
5	Replace Window	2011	2,919		20	146	146	535	5
6	Replace Temp Valves	2011	2,825		20	141	141	518	6
7	Install Pipe Line	2011	4,953		20	248	248	784	7
8	Pull Station Covers	2011	2,994		20	150	150	549	8
9	Floor Registers	2012	2,699		20	135	135	405	9
10	Custom Cabinets	2012	8,000		20	400	400	1,167	10
11	Cabinetry-Reception	2012	2,900		20	145	145	423	11
12	Nurse Station	2012	19,800		20	990	990	2,310	12
13	Electrical Wiring	2012	3,805		20	190	190	444	13
14	Emergency Lights	2012	3,605		20	180	180	391	14
15	Furnace	2012	5,362		20	268	268	581	15
16	Lobby Window Treatment	2012	2,705		20	135	135	383	16
17	Retile Facility	2012	95,887		20	4,794	4,794	12,785	17
18	Retile Facility	2012	94,518		20	4,726	4,726	12,602	18
19	Sprinkler Heads	2012	3,832		20	192	192	447	19
20	Retaining Wall & Landscaping	2012	10,000		20	500	500	1,208	20
21	Magnetic Door Locks	2013	3,401		20	170	170	340	21
22	Run New Hot Water Lines - Breakroom & Kitchen	2013	7,237		20	362	362	633	22
23	Weld Metal Door & Frames With Existing Wall Anchors	2013	5,320		20	266	266	466	23
24	Relocate Phone Line, Install Rcptcls, Door Magnets In Staff Desk,	2013	2,906		20	145	145	230	24
25	Painting 12 Rooms In D Hallway	2013	3,600		20	180	180	270	25
26	Painting 12 Rooms In E Hallway	2013	3,600		20	180	180	240	26
27	Painting 12 Rooms In G Hallway	2013	3,600		20	180	180	225	27
28	Seal And Stripe Parking Lot	2013	3,300		20	165	165	206	28
29	Painting 12 Rooms In C Hallway	2013	3,600		20	180	180	195	29
30	Rebuilt Tempering Valve Ghall,D/E/A/ Wing Mechanical Rooms	2014	6,174		20	77	77	77	30
31	Concrete Pad (Patio) And Driveway	2014	14,300		20	179	179	179	31
32	Freezer	2014	6,482		20	162	162	162	32
33	Painting -Prep 71 Rms/ 12 Rms B Hall / 1 Rm F Hall	2014	5,650		20	283	283	283	33
34	TOTAL (lines 1 thru 33)		$ 4,232,715	$ 188,504		$ 149,698	$ (38,806)	$ 894,909	34

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

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 4,232,715	$ 188,504		$ 149,698	$ (38,806)	$ 894,909	1
2	24 Interior Rooms Painted	2014	10,000		20	500	500	500	2
3	Electrical Repairs / Lighting Replaced In Laundry Room/Kitchen/I	2014	8,083		20	320	320	320	3
4	A&B Wing Painting	2014	3,600		20	180	180	180	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,254,398	$ 188,504		$ 150,698	$ (37,806)	$ 895,909	34

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

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 4,254,398	$ 188,504		$ 150,698	$ (37,806)	$ 895,909	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,254,398	$ 188,504		$ 150,698	$ (37,806)	$ 895,909	34

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

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 4,254,398	$ 188,504		$ 150,698	$ (37,806)	$ 895,909	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,254,398	$ 188,504		$ 150,698	$ (37,806)	$ 895,909	34

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

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12E, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9	Roof	2008	83,141	5,543	20	4,157	(1,386)	22,633	9
10	Hand Rails	2008	41,519	4,152	20	2,076	(2,076)	11,072	10
11	Demolition, Framing,Plumbing, Heating…	2008	71,200	3,560	20	3,560		19,580	11
12	Demolition, Electical,Plumbing, Painting,Flooring….	2008	455,946	22,797	20	22,797		117,785	12
13	Painting Doors	2008	7,840	784	20	392	(392)	2,025	13
14	Draperies	2008	35,206	3,521	20	1,760	(1,761)	8,865	14
15	Trane A/C Unit	2010	12,989	649	20	649		2,596	15
16	Fire Alarm	2010	7,539	377	20	377		1,508	16
17	Rooftop Heat Exchanger	2010	9,900	495	20	495		1,980	17
18	Satellite TV Install	2010	11,930	909	20	909		3,636	18
19	Paving Parking Lot	2010	12,000	600	20	600		2,400	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)		$ 749,210	$ 43,387		$ 37,772	$ (5,615)	$ 194,080	34

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

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 749,210	$ 43,387		$ 37,772	$ (5,615)	$ 194,080	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 749,210	$ 43,387		$ 37,772	$ (5,615)	$ 194,080	34

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

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from S.I.R. Management	2009	15,120		39	388	388	1,955	3
4	Allocated - S.I.R Properties - S.I.R. Management	1993	27,378	869	35	782	(87)	16,817	4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from S.I.R. Management	1994	22		20			22	9
10	Allocated from S.I.R. Management	1995	159		20	8	8	154	10
11	Allocated from S.I.R. Management	1997	10,666	239	20	520	281	9,447	11
12	Allocated from S.I.R. Management	1999	839		20	42	42	639	12
13	Allocated from S.I.R. Management	2000	990		20	49	49	720	13
14	Allocated from S.I.R. Management	2007	3,181	217	20	159	(58)	1,144	14
15	Allocated from S.I.R. Management	2008	8,767	838	20	553	(285)	3,782	15
16	Allocated from S.I.R. Management	2009	21,786	199	20	1,089	890	5,713	16
17	Allocated from S.I.R. Management	2011	539	54	20	54		184	17
18	Allocated from S.I.R. Management	2012	1,725	86	20	86		208	18
19	Allocated from S.I.R. Management	1993	6,941	193	20		(193)	6,941	19
20	Allocated from S.I.R. Management	2014	242		20	7	7	7	20
21	Allocated - S.I.R Properties - S.I.R. Management	2012	1,677	165	20	8	(157)	22	21
22	Allocated - S.I.R Properties - S.I.R. Management	2010	1,652		20	83	83	358	22
23	Allocated - S.I.R Properties - S.I.R. Management	2009	1,644	73	20	82	9	477	23
24	Allocated - S.I.R Properties - S.I.R. Management	2007	479	24	20	24		192	24
25	Allocated - S.I.R Properties - S.I.R. Management	2002	108		20	5	5	68	25
26	Allocated - S.I.R Properties - S.I.R. Management	1999	3,469		20	173	173	2,689	26
27	Allocated - S.I.R Properties - S.I.R. Management	1998	1,658		20	83	83	1,368	27
28	Allocated - S.I.R Properties - S.I.R. Management	1997	103		20	5	5	95	28
29	Allocated - S.I.R Properties - S.I.R. Management	1994	261	7	20	7		261	29
30	Allocated - S.I.R Properties - S.I.R. Management	1993	444	2	20		(2)	444	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 109,850	$ 2,966		$ 4,207	$ 1,241	$ 53,707	34

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

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 109,850	$ 2,966		$ 4,207	$ 1,241	$ 53,707	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 109,850	$ 2,966		$ 4,207	$ 1,241	$ 53,707	34

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

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,186,851	$ 63,686	$ 118,549	$ 54,863	10	$ 666,873	71
72	Current Year Purchases	20,909	112	1,022	910	10	1,022	72
73	Fully Depreciated Assets	24,396				10	24,396	73
74								74
75	TOTALS	$ 1,232,156	$ 63,798	$ 119,571	$ 55,773		$ 692,291	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		GMAC VAN	2008	$ 30,038	$	$	$	5	$ 30,038	76
77		S.I.R. Management		2,126	193	227	34	5	1,225	77
78										78
79										79
80	TOTALS			$ 32,164	$ 193	$ 227	$ 34		$ 31,263	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,618,718	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 252,495	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 270,495	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 18,000	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,619,463	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	HYUNDAI - 2010	$ 16,300	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 16,300	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2015	$
13.	/2016	$
14.	/2017	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 8,424 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from S.I.R.		$	$ 4,120	17
18					18
19					19
20					20
21	TOTAL		$	$ 4,120	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 # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental						539		539	13
14	TOTAL			$		$	$ 539		$ 539	14

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

STATE OF ILLINOIS

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/14 (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	$ 56,987	$ 99,613	1
2	Cash-Patient Deposits	11,823	11,823	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	871,865	871,865	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,684	16,684	6
7	Other Prepaid Expenses	3,814	3,814	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	3,382	3,382	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 964,555	$ 1,007,181	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	352,869	1,024,515	15
16	Equipment, at Historical Cost	306,482	1,365,521	16
17	Accumulated Depreciation (book methods)	(223,622)	(1,572,536)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		8,735	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(4,247)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	1,166,879	2,616,879	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,602,608	$ 6,441,742	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,567,163	$ 7,448,923	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 125,579	$ 125,578	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,823	11,823	28
29	Short-Term Notes Payable	450,000	450,000	29
30	Accrued Salaries Payable	110,470	110,470	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,132	10,132	31
32	Accrued Real Estate Taxes(Sch.IX-B)		48,600	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	33,843	33,843	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 741,847	$ 790,446	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,361	2,361	39
40	Mortgage Payable		3,583,283	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43			1,030,685	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,361	$ 4,616,329	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 744,208	$ 5,406,775	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,822,955	$ 2,042,148	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,567,163	$ 7,448,923	48

*(See instructions.)

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,683,656	1
2	Restatements (describe):		2
3			3
4	**Rounding**	2	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,683,658	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	705,497	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	(566,200)	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)**	$ 139,297	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,822,955	24 *

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

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 4,785,597	1
2	Discounts and Allowances for all Levels	(15,482)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,770,115	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	104	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	43,325	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)**	$ 43,429	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	30,000	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 30,000	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	2,789	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,789	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,846,333	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,029,407	31
32	Health Care	1,431,708	32
33	General Administration	1,214,646	33
	B. Capital Expense		
34	Ownership	464,536	34
	C. Ancillary Expense		
35	Special Cost Centers	539	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,140,836	40
41	**Income before Income Taxes (line 30 minus line 40)****	705,497	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 705,497	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,262,762	44
45	Private Pay - Net Inpatient Revenue	119,991	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Veterans	200,326	47
48	Other-(specify) Managed Care	187,036	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,770,115	49

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

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

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

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

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,082	2,324	$ 80,453	$ 34.62	1
2	Assistant Director of Nursing	2,013	2,136	61,725	28.90	2
3	Registered Nurses	2,509	2,604	60,494	23.23	3
4	Licensed Practical Nurses	11,391	11,966	233,709	19.53	4
5	CNAs & Orderlies	48,753	51,074	472,225	9.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,287	1,391	17,644	12.68	9
10	Activity Assistants	4,539	4,812	42,127	8.75	10
11	Social Service Workers	10,703	11,324	150,696	13.31	11
12	Dietician					12
13	Food Service Supervisor	2,567	2,764	41,454	15.00	13
14	Head Cook	469	485	4,435	9.14	14
15	Cook Helpers/Assistants	15,484	15,967	135,627	8.49	15
16	Dishwashers					16
17	Maintenance Workers	3,747	3,995	55,482	13.89	17
18	Housekeepers	12,670	13,466	138,626	10.29	18
19	Laundry	3,716	3,952	33,509	8.48	19
20	Administrator	1,959	2,096	98,017	46.76	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,115	8,757	109,014	12.45	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	3,891	4,352	80,520	18.50	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,416	1,416	5,840	4.12	33
34	TOTAL (lines 1 - 33)	137,311	144,881	$ 1,821,597 *	$ 12.57	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 28,633	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant	Monthly	663	10-03	37
38	Nurse Consultant	Monthly	35,280	10-03	38
39	Pharmacist Consultant	9,882	10,698	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	Quarterly	902	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Specialized Rehab Consultant	Monthly	17,640	10a-03	47
48	Psych Medical Director	Monthly	48,000	10-03	48
49	TOTAL (lines 35 - 48)	9,882	$ 159,816		49

C. CONTRACT NURSES

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

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ruth Huber	Administarator	0	$ 98,017
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 98,017

B. Administrative - Other

Description	Amount
SIR Management - Management Fees	$ 239,546
SIR Management - Ancillary Admin. Charges	35,280
TOTAL (agree to Schedule V, line 17, col. 3)	$ 274,826
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SIR Management	Dir of Regulatory Services	$ 17,640
SIR Management	Bookkeeping	58,212
Personnel Planners	Unemployment Consulting	2,144
FROST	Accounting Fees	12,195
Various	Legal Fees	898
HK Payroll Services	WOTC Consulting	1,883
SIR Management	Dir of Financing	36,000
Pinnacle	Customer Satisfaction	2,666
SIR Management	Accounting Fees	2,900
SIR Management	Dir of Admin	35,280
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 169,818

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 17,501
Unemployment Compensation Insurance	68,231
FICA Taxes	136,401
Employee Health Insurance	57,136
Employee Meals	6,497
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	4,905
TOTAL (agree to Schedule V, line 22, col.8)	$ 290,670

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,992
Advertising: Employee Recruitment	2,446
Health Care Worker Background Check	
(Indicate # of checks performed 100)	1,000
Patient Background Checks 351	3,512
Dues & Subscriptions	13,060
Licenses & Permits	1,102
Alloc. From S.I.R. Management	2,233
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,345

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,888
SIR Management	626
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,514

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 - $ 18,134**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,898** 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. $ **6,497** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

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

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

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

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