FOR BHF USE

LL1

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

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/15 to 12/31/15 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)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/15 Ending: 12/31/15

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	13,795	641	33,800	48,236	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,795	641	33,800	48,236	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.90%

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 [X]

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

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

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

STATE OF ILLINOIS

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	183,827	21,322	29,628	234,777		234,777	(11,314)	223,463			1
2	Food Purchase		252,052		252,052	(6,169)	245,884	(587)	245,297			2
3	Housekeeping	135,028	36,083		171,111		171,111		171,111			3
4	Laundry	32,423	21,584		54,007		54,007		54,007			4
5	Heat and Other Utilities			109,710	109,710		109,710	(8,880)	100,830			5
6	Maintenance	53,131	20,995	111,179	185,305		185,305	(7,732)	177,573			6
7	Other (specify):*							2,224	2,224			7
8	**TOTAL General Services**	404,409	352,036	250,517	1,006,962	(6,169)	1,000,794	(26,288)	974,505			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,018,300	64,736	103,078	1,186,114		1,186,114	(25,471)	1,160,643			10
10a	Therapy			24,696	24,696		24,696	(11,779)	12,917			10a
11	Activities	75,534	16,757	1,243	93,534		93,534		93,534			11
12	Social Services	171,061			171,061		171,061		171,061			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							5,810	5,810			15
16	**TOTAL Health Care and Programs**	1,264,895	81,493	129,017	1,475,405		1,475,405	(31,441)	1,443,964			16
	C. General Administration											
17	Administrative	102,483		323,388	425,871		425,871	(229,234)	196,637			17
18	Directors Fees											18
19	Professional Services			223,434	223,434		223,434	(147,966)	75,468			19
20	Dues, Fees, Subscriptions & Promotions			57,237	57,237		57,237	(29,501)	27,736			20
21	Clerical & General Office Expenses	109,860	26,024	62,335	198,219		198,219	79,188	277,407			21
22	Employee Benefits & Payroll Taxes			258,363	258,363	6,169	264,532		264,532			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,214	3,214		3,214	1,019	4,233			24
25	Other Admin. Staff Transportation			11,303	11,303		11,303	6,030	17,333			25
26	Insurance-Prop.Liab.Malpractice			96,817	96,817		96,817	2,010	98,827			26
27	Other (specify):*							34,063	34,063			27
28	**TOTAL General Administration**	212,343	26,024	1,036,091	1,274,458	6,169	1,280,627	(284,391)	996,236			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,881,647	459,553	1,415,625	3,756,825		3,756,825	(342,120)	3,414,705			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: 01/01/15 Ending: 12/31/15

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			50,636	50,636		50,636	225,665	276,301			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,238	10,238		10,238	156,306	166,544			32
33	Real Estate Taxes							55,744	55,744			33
34	Rent-Facility & Grounds			408,000	408,000		408,000	(408,000)				34
35	Rent-Equipment & Vehicles			6,727	6,727		6,727	5,732	12,459			35
36	Other (specify):*											36
37	**TOTAL Ownership**			475,601	475,601		475,601	35,447	511,048			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		150		150		150		150			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**		150		150		150		150			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,881,647	459,703	1,891,226	4,232,576		4,232,576	(306,673)	3,925,903			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: 01/01/15 Ending: 12/31/15

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 Reference	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	(10,908)	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	17,874	30		9
10	Interest and Other Investment Income	(54,205)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(33)	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	(13,633)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(19,158)	21		24
25	Fund Raising, Advertising and Promotional	(8,273)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(7,660)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(46,184)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (142,180)		$	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)	(164,492)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (164,492)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (306,673)		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: **01/01/15**

Ending: **12/31/15**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Building Co. - Amortization	$ (1,456)	36	1
2	Building Co. - Filing Fees	(250)	21	2
3	Building Co. - Office Expenses	(95)	21	3
4	Additional R&M	4,838	6	4
5	Veterans Prescription Drugs	(23,304)	10	5
6	Bank Fees	(6,710)	21	6
7	Theft & Damage	(50)	21	7
8	Misc Income	(255)	21	8
9	Dues & Subscriptions - PAC	(9,000)	20	9
10	Non-allowable Legal	(9,349)	19	10
11	Vending Income	(553)	02	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(46,184)		49

Decatur Manor Healthcare

ID# 0049262

Report Period Beginning: 01/01/15

Ending: 12/31/15

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Decatur Manor Healthcare # 0049262 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary				(11,314)								(11,314)	1
2	Food Purchase	(587)											(587)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(10,908)			2,028								(8,880)	5
6	Maintenance	4,838		(16,913)	4,343								(7,732)	6
7	Other (specify):*				2,224								2,224	7
8	**TOTAL General Services**	(6,657)		(16,913)	(2,719)								(26,288)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(23,304)		(9,144)	6,977								(25,471)	10
10a	Therapy				(11,779)								(11,779)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			3,026	2,784								5,810	15
16	**TOTAL Health Care and Programs**	(23,304)		(6,118)	(2,019)								(31,441)	16
	C. General Administration													
17	Administrative			(300,707)	71,473								(229,234)	17
18	Directors Fees													18
19	Professional Services	(9,349)		(152,204)	13,587								(147,966)	19
20	Fees, Subscriptions & Promotions	(30,906)		1,405									(29,501)	20
21	Clerical & General Office Expenses	(34,178)	345	112,931	90								79,188	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,019									1,019	24
25	Other Admin. Staff Transportation			6,030									6,030	25
26	Insurance-Prop.Liab.Malpractice			1,814	196								2,010	26
27	Other (specify):*			18,647	15,416								34,063	27
28	**TOTAL General Administration**	(74,433)	345	(311,065)	100,762								(284,391)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(104,394)	345	(334,096)	96,024								(342,120)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Decatur Manor Healthcare # 0049262 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	17,874	201,514		6,277								225,665	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(54,205)	217,078	(12,149)	5,582								156,306	32
33	Real Estate Taxes		48,498		7,246								55,744	33
34	Rent-Facility & Grounds		(408,000)										(408,000)	34
35	Rent-Equipment & Vehicles			5,732									5,732	35
36	Other (specify):*	(1,456)	1,456											36
37	**TOTAL Ownership**	(37,787)	60,546	(6,417)	19,105								35,447	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)**	(142,180)	60,891	(340,513)	115,129								(306,673)	45

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/15 Ending: 12/31/15

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%	201,514	201,514	3
4	V	21	Filing Fees		Decatur Healthcare Estates	100.00%	250	250	4
5	V	32	Interest Expense		Decatur Healthcare Estates	100.00%	217,137	217,137	5
6	V	21	Office		Decatur Healthcare Estates	100.00%	95	95	6
7	V	33	Real Estate Taxes	1,002	Decatur Healthcare Estates	100.00%	49,500	48,498	7
8	V	32	Interest Income	59	Decatur Healthcare Estates	100.00%		(59)	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 409,061			$ 469,952	$ * 60,891	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: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS AND MAINT.	$ 21,168	S.I.R. MANAGEMENT, INC.	100.00%	$ 4,255	$ (16,913)	15
16	V								16
17	V	10	NURSING	42,336	S.I.R. MANAGEMENT, INC.	100.00%	33,192	(9,144)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	3,026	3,026	18
19	V	19	PROFESSIONAL FEES	156,024	S.I.R. MANAGEMENT, INC.	100.00%	3,434	(152,590)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	1,405	1,405	20
21	V	21	CLERICAL & GENERAL	7,056	S.I.R. MANAGEMENT, INC.	100.00%	107,633	100,577	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	1,019	1,019	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	6,030	6,030	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,814	1,814	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	5,699	5,699	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(12,149)	(12,149)	26
27	V	35	AUTO RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	4,873	4,873	27
28	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	859	859	28
29	V								29
30	V	17	ADMINISTRATIVE	323,388	S.I.R. MANAGEMENT, INC.	100.00%	22,681	(300,707)	30
31	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	386	386	31
32	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	12,354	12,354	32
33	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	12,948	12,948	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 549,972			$ 209,459	$ * (340,513)	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: 01/01/15 Ending: 12/31/15

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%	$ 6,326	$ (11,314)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	882	882	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	6,977	6,977	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	966	966	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	71,473	71,473	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	13,520	13,520	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	15,416	15,416	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	24,696	S.I.R. MANAGEMENT, INC.	100.00%	12,917	(11,779)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,818	1,818	25
26	V								26
27	V	6	MAINTENANCE SALARIES	5,762	S.I.R. MANAGEMENT, INC.	100.00%	8,966	3,204	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,342	1,342	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	2,028	2,028	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	1,139	1,139	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	67	67	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	90	90	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	196	196	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	6,277	6,277	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	5,582	5,582	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	7,246	7,246	37
38	V								38
39	Total			$ 48,098			$ 163,227	$ * 115,129	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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ATIED ASSOCIATES, LLC	26.39%	ALBANY CARE INC	EVANSTON	DECATUR HEALTHCARE ESTA	LINCOLNWOOD	BUILDING CO.	1
2	BARRISH GROUP LIMITED	8.80%	APPLEWOOD REHABILITATION CENTER,LLC	MATTESON	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	2
3	BRYAN BARRISH TRUST	8.80%	BRYN MAWR CARE INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	FAY CHIN	1.34%	COLUMBUS PARK NURSING & REHABILITATION CENTER, INC.	CHICAGO	OAKTON ARMS	DES PLAINES	ASSISTED LIVING	4
5	JEFF ORAVEC	1.34%	ELMWOOD CARE, INC.	ELMWOOD PARK				5
6	LOUISE BERGTHOLD	3.36%	OAKTON PAVILION	DES PLAINES				6
7	LYNN ETHELL	1.34%	GREENWOOD CARE, INC.	EVANSTON				7
8	NENITA GUZMAN	1.34%	WESLEY REHABILITATION CENTER	AUBURN, IN				8
9	PATRICIA MCDIARMID	1.34%	NEIGHBORS REHABILITATION CENTER,LLC	BYRON				9
10	RALPH GESUALDO	8.80%	REGENCY REHABILITATION CENTER,LLC	NILES				10
11	RALPH GESUALDO CHILDREN'S TRUST	8.80%	ROCK ISLAND NURSING & REHAB CENTER,LLC	ROCK ISLAND				11
12	RONALD NUNZIATO JR.	2.67%	WILSON CARE, INC.	CHICAGO				12
13	THOMAS WINTER	6.71%						13
14	UNITED TRUST #1	4.40%						14
15	UNITED TRUST #2	4.40%						15
16	L.G. TRUST	4.39%						16
17	B.G. TRUST	4.39%						17
18	KIM SHELTON	1.34%						18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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	4.01	6.68%	Alloc. Salary	$ 13,376	17-07	1
2	Louise Bergthold	Shareholder	Administrative	3.36%	See Attached	4.01	6.68%	Alloc. Salary	13,376	17-07	2
3	Patricia Mcdiarmid	Shareholder	Administrative	1.34%	See Attached	3.34	6.68%	Alloc. Salary	11,038	17-07	3
4	Andrew Chin	Relative	Clerical		See Attached	2.68	6.70%	Alloc. Salary	5,161	21-07	4
5	Jeff Oravec	Shareholder	Administrative	1.34%	See Attached	2.68	6.70%	Alloc. Salary	9,304	17-07	5
6	Fay Chin	Shareholder	Nursing	1.34%	See Attached	2.68	6.70%	Alloc. Salary	6,977	10-07	6
7	Nenita Guzman	Shareholder	Dietary	1.34%	See Attached	3.34	6.68%	Alloc. Salary	6,326	01-07	7
8	Kim Shelton	Shareholder	Clerical	1.34%	See Attached	2.68	6.70%	Alloc. Salary	4,854	21-07	8
9											9
10	See Supplemental Schedule								41,064		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	$ 111,476		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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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	721,222	14	$ 63,617	$	48,236	$ 4,255	1
2										2
3	10	NURSING	PATIENT DAYS	721,222	14	496,290	496,290	48,236	33,192	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	721,222	14	45,246		48,236	3,026	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	721,222	14	51,349		48,236	3,434	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	721,222	14	21,010		48,236	1,405	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	721,222	14	1,609,327	1,193,369	48,236	107,633	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	721,222	14	15,238		48,236	1,019	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	721,222	14	90,162		48,236	6,030	9
10	26	INSURANCE	PATIENT DAYS	721,222	14	27,120		48,236	1,814	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	721,222	14	85,206		48,236	5,699	11
12	32	INTEREST	PATIENT DAYS	721,222	14	(181,648)		48,236	(12,149)	12
13	35	AUTO RENTAL	PATIENT DAYS	721,222	14	72,863		48,236	4,873	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	721,222	14	12,850		48,236	859	14
15										15
16	17	ADMINISTRATIVE	PATIENT DAYS	721,222	14	339,119	339,119	48,236	22,681	16
17	19	PROFESSIONAL FEES	PATIENT DAYS	721,222	14	5,774		48,236	386	17
18	21	CLERICAL & GENERAL	PATIENT DAYS	721,222	14	184,716	77,164	48,236	12,354	18
19	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	721,222	14	193,599		48,236	12,948	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,131,838	$ 2,105,942		$ 209,459	25

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	721,222	14	$ 94,587	$ 94,587	48,236	$ 6,326	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	721,222	14	13,188		48,236	882	2
3	10	NURSING SALARIES	PATIENT DAYS	721,222	14	104,315	104,315	48,236	6,977	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	721,222	14	14,440		48,236	966	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	721,222	14	1,068,659	1,068,659	48,236	71,473	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	721,222	14	202,147		48,236	13,520	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	721,222	14	230,505		48,236	15,416	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	322,920	13	168,894	168,894	24,696	12,917	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	322,920	13	23,767		24,696	1,818	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	319,657	14	497,427	497,427	5,762	8,966	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	319,657	14	74,439		5,762	1,342	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,878	14	30,338		861	2,028	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,878	14	17,037		861	1,139	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,878	14	1,002		861	67	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,878	14	1,351		861	90	19
20	26	INSURANCE	ALLOCATED SQ FT	12,878	14	2,937		861	196	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,878	14	93,883		861	6,277	21
22	32	INTEREST	ALLOCATED SQ FT	12,878	14	83,486		861	5,582	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,878	14	108,372		861	7,246	23
24										24
25	TOTALS					$ 2,830,774	$ 1,933,882		$ 163,227	25

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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			$	$ 3,461,091			$ 217,137	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Lake Forest Bank & Trust		X	Line of Credit		04/02/2008		50,000		0.0500	10,238	6
7	Alloc - SIR Management										5,582	7
8												8
9	TOTAL Facility Related						$	$ 3,511,091			$ 232,957	9
	B. Non-Facility Related*											
10	Interest Income		X								(54,205)	10
11	Interest Income - Bldg Co		X								(59)	11
12	Alloc - SIR Management										(12,149)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (66,413)	14
15	TOTALS (line 9+line14)						$	$ 3,511,091			$ 166,544	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: 01/01/15 Ending: 12/31/15

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												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											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:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	48,600	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	54,844	2
3. Under or (over) accrual (line 2 minus line 1).	$	6,244	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)	$	49,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**	$		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.	$	55,744	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	75,972	8
	2011	60,024	9
	2012	46,308	10
	2013	46,700	11
	2014	47,598	12

2015 Accrual = $47,597.82 x 1.04 = $49,500
Allocated from S.I.R. Managment -$7,246

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 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 2014 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 2014.

	(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	$ 47,597.82	$ 47,597.82
2.	See Attached	Home Office Allocation	$ 118,674.75	$ 6,213.86
3.	See Attached	Regency Property Allocation	$ 862,948.02	$ 700.42
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,029,220.59	$ 54,512.10

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	147		2008	1976	$ 2,902,875	$ 46,240	35	$ 82,939	$ 36,699	$ 651,904	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2008	11,477		20	1,148	1,148	8,739	9
10	Various			2009	26,920		20	1,346	1,346	8,677	10
11	Various			2010	26,169		20	1,966	1,966	13,938	11
12	Various			2011	83,931		20	4,474	4,474	19,085	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: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		749,210	68,530		37,772	(30,758)	296,116	67
68	Related Party Allocations (Pages 12H & 12I)		138,147	3,899		5,073	1,174	66,603	68
69	Financial Statement Depreciation			50,636			(50,636)		69
70	TOTAL (lines 4 thru 69)		$ 3,938,729	$ 169,305		$ 134,718	$ (34,587)	$ 1,065,062	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: 01/01/15 Ending: 12/31/15

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		$ 3,938,729	$ 169,305		$ 134,718	$ (34,587)	$ 1,065,062	1
2	Floor Registers	2012	2,699		20	135	135	540	2
3	Custom Cabinets	2012	8,000		20	400	400	1,567	3
4	Cabinetry-Reception	2012	2,900		20	145	145	568	4
5	Nurse Station	2012	19,800		20	990	990	3,300	5
6	Electrical Wiring	2012	3,805		20	190	190	634	6
7	Emergency Lights	2012	3,605		20	180	180	571	7
8	Furnace	2012	5,362		20	268	268	849	8
9	Lobby Window Treatment	2012	2,705		20	135	135	518	9
10	Retile Facility	2012	95,887		20	4,794	4,794	17,579	10
11	Retile Facility	2012	94,518		20	4,726	4,726	17,328	11
12	Sprinkler Heads	2012	3,832		20	192	192	639	12
13	Retaining Wall & Landscaping	2012	10,000		20	500	500	1,708	13
14	Magnetic Door Locks	2013	3,401		20	170	170	510	14
15	Run New Hot Water Lines - Breakroom & Kitchen	2013	7,237		20	362	362	995	15
16	Weld Metal Door & Frames With Existing Wall Anchors	2013	5,320		20	266	266	732	16
17	Relocate Phone Line, Install Rcptcls, Door Magnets In Staff Desk,	2013	2,906		20	145	145	375	17
18	Painting 12 Rooms In D Hallway	2013	3,600		20	180	180	450	18
19	Painting 12 Rooms In E Hallway	2013	3,600		20	180	180	420	19
20	Painting 12 Rooms In G Hallway	2013	3,600		20	180	180	405	20
21	Seal And Stripe Parking Lot	2013	3,300		20	165	165	371	21
22	Painting 12 Rooms In C Hallway	2013	3,600		20	180	180	375	22
23	Rebuilt Tempering Valve	2014	6,174		20	309	309	386	23
24	Concrete Pad (Patio) And Driveway	2014	14,300		20	715	715	894	24
25	Freezer	2014	6,482		20	648	648	810	25
26	Painting-Prep 71 Rms / 12 Rms B Hall / 1 Rm F Hall	2014	5,650		20	283	283	541	26
27	24 Interior Rooms Painted	2014	10,000		20	500	500	708	27
28	Electrical Repairs, Lighting Replaced In Laundry Room, Kitchen,	2014	8,083		20	404	404	707	28
29	A&B Wing Painting	2014	3,600		20	180	180	195	29
30	Hot Water Heater	2015	5,325		20	266	266	266	30
31	Roof Work (West)	2015	10,350		20	345	345	345	31
32	Hot Water Heater	2015	10,956		20	183	183	183	32
33	Laminate Flooring (4 Rooms)	2015	6,590		20	82	82	82	33
34	TOTAL (lines 1 thru 33)		$ 4,315,916	$ 169,305		$ 153,116	$ (16,189)	$ 1,120,615	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: 01/01/15 Ending: 12/31/15

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		$ 4,315,916	$ 169,305		$ 153,116	$ (16,189)	$ 1,120,615	1
2	Wireless Network	2015	6,988		20	116	116	116	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)		$ 4,322,904	$ 169,305		$ 153,233	$ (16,072)	$ 1,120,731	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: 01/01/15 Ending: 12/31/15

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		$ 4,322,904	$ 169,305		$ 153,233	$ (16,072)	$ 1,120,731	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)		$ 4,322,904	$ 169,305		$ 153,233	$ (16,072)	$ 1,120,731	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: 01/01/15 Ending: 12/31/15

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		$ 4,322,904	$ 169,305		$ 153,233	$ (16,072)	$ 1,120,731	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)		$ 4,322,904	$ 169,305		$ 153,233	$ (16,072)	$ 1,120,731	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: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Roof	2008	83,141		20	4,157	4,157	33,256	9
10	Hand Rails	2008	41,519		20	2,076	2,076	16,608	10
11	Demolition, Framing,Plumbing, Heating…	2008	71,200		20	3,560	3,560	28,480	11
12	Demolition, Electical,Plumbing, Painting,Flooring….	2008	455,946		20	22,797	22,797	182,376	12
13	Painting Doors	2008	7,840		20	392	392	3,136	13
14	Draperies	2008	35,206		20	1,760	1,760	14,080	14
15	Trane A/C Unit	2010	12,989		20	649	649	3,894	15
16	Fire Alarm	2010	7,539		20	377	377	2,262	16
17	Rooftop Heat Exchanger	2010	9,900		20	495	495	2,970	17
18	Satellite TV Install	2010	11,930		20	909	909	5,454	18
19	Paving Parking Lot	2010	12,000		20	600	600	3,600	19
20									20
21									21
22	Building Company Current Depreciation			68,530			(68,530)		22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 749,210	$ 68,530		$ 37,772	$ (30,758)	$ 296,116	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: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 749,210	$ 68,530		$ 37,772	$ (30,758)	$ 296,116	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	$ 68,530		$ 37,772	$ (30,758)	$ 296,116	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: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from S.I.R. Management	2009	33,429	857	39	857		5,179	3
4	Allocated - S.I.R Properties - S.I.R. Management	1993	30,264	961	35	865	(96)	19,455	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from S.I.R. Management	1994	7,673	214	20		(214)	7,673	9
10	Allocated from S.I.R. Management	1995	24		20			24	10
11	Allocated from S.I.R. Management	1997	175		20	5	5	175	11
12	Allocated from S.I.R. Management	1999	11,790	264	20	575	311	11,018	12
13	Allocated from S.I.R. Management	2000	927		20	46	46	753	13
14	Allocated from S.I.R. Management	2007	1,095		20	55	55	851	14
15	Allocated from S.I.R. Management	2008	3,517		20	176	176	1,441	15
16	Allocated from S.I.R. Management	2009	9,692	969	20	611	(358)	4,792	16
17	Allocated from S.I.R. Management	2011	24,083	220	20	1,204	984	7,519	17
18	Allocated from S.I.R. Management	2012	596	60	20	60		263	18
19	Allocated from S.I.R. Management	1993	1,907	95	20	95		326	19
20	Allocated from S.I.R. Management	2014	267	27	20	13	(14)	21	20
21	Allocated - S.I.R Properties - S.I.R. Management	2012	1,854	130	20	7	(123)	33	21
22	Allocated - S.I.R Properties - S.I.R. Management	2010	1,826		20	91	91	487	22
23	Allocated - S.I.R Properties - S.I.R. Management	2009	1,817	81	20	91	10	618	23
24	Allocated - S.I.R Properties - S.I.R. Management	2007	530	11	20	26	15	238	24
25	Allocated - S.I.R Properties - S.I.R. Management	2002	120		20	6	6	81	25
26	Allocated - S.I.R Properties - S.I.R. Management	1999	3,835		20	192	192	3,164	26
27	Allocated - S.I.R Properties - S.I.R. Management	1998	1,833		20	92	92	1,604	27
28	Allocated - S.I.R Properties - S.I.R. Management	1997	114		20	6	6	109	28
29	Allocated - S.I.R Properties - S.I.R. Management	1994	288	7	20		(7)	288	29
30	Allocated - S.I.R Properties - S.I.R. Management	1993	491	3	20		(3)	491	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 138,147	$ 3,899		$ 5,073	$ 1,174	$ 66,603	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: 01/01/15 Ending: 12/31/15

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		$ 138,147	$ 3,899		$ 5,073	$ 1,174	$ 66,603	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)		$ 138,147	$ 3,899		$ 5,073	$ 1,174	$ 66,603	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: 01/01/15 Ending: 12/31/15

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	$ 1,213,691	$ 88,918	$ 121,973	$ 33,055	10	$ 792,956	71
72	Current Year Purchases	10,100		842	842	10	842	72
73	Fully Depreciated Assets	27,033		4	4	10	27,033	73
74								74
75	TOTALS	$ 1,250,824	$ 88,918	$ 122,819	$ 33,901		$ 820,831	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		GMAC VAN	2008	$ 30,038	$	$	$	5	$ 30,038	76
77		Allocated from SIR Management	2015	2,350	205	251	46	5	1,605	77
78										78
79										79
80	TOTALS			$ 32,388	$ 205	$ 251	$ 46		$ 31,643	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)	$ 5,706,116	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 258,428	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 276,302	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 17,874	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,973,205	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: 01/01/15 Ending: 12/31/15

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.	/2016	$
13.	/2017	$
14.	/2018	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 7,588 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 SIR Management		$	$ 4,873	17
18					18
19					19
20					20
21	TOTAL		$	$ 4,873	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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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						150		150	13
14	TOTAL			$		$	$ 150		$ 150	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:** 01/01/15 **Ending:** 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/15 **(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	$ 99,259	$ 133,859	1
2	Cash-Patient Deposits	29,550	29,550	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	526,397	526,397	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,585	15,585	6
7	Other Prepaid Expenses	1,822	1,822	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 672,613	$ 707,213	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	393,078	1,064,724	15
16	Equipment, at Historical Cost	321,421	1,380,460	16
17	Accumulated Depreciation (book methods)	(274,258)	(1,824,686)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		8,735	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(5,703)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	1,166,879	1,649,980	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,607,120	$ 5,276,385	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,279,733	$ 5,983,598	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 123,679	$ 123,680	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	29,576	29,576	28
29	Short-Term Notes Payable	50,000	50,000	29
30	Accrued Salaries Payable	44,688	44,688	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,560	2,560	31
32	Accrued Real Estate Taxes(Sch.IX-B)		49,500	32
33	Accrued Interest Payable		986	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	33,547	33,547	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 284,050	$ 334,537	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,461,091	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43			63,786	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 3,524,877	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 284,050	$ 3,859,414	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,995,683	$ 2,124,184	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,279,733	$ 5,983,598	48

***(See instructions.)**

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/15 Ending: 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,822,955	1
2	Restatements (describe):		2
3	**Rounding**	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,822,956	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	753,827	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	(581,100)	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)**	$ 172,727	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)**	$ 1,995,683	24 *

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

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 4,913,683	1
2	Discounts and Allowances for all Levels	(6,118)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,907,565	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	96	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	23,303	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)**	$ 23,399	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	54,205	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 54,205	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,234	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,234	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,986,403	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,006,962	31
32	Health Care	1,475,405	32
33	General Administration	1,274,458	33
	B. Capital Expense		
34	Ownership	475,601	34
	C. Ancillary Expense		
35	Special Cost Centers	150	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)***	$ 4,232,576	40
41	**Income before Income Taxes (line 30 minus line 40)****	753,827	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 753,827	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,376,082	44
45	Private Pay - Net Inpatient Revenue	73,975	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Veterans	95,514	47
48	Other-(specify) Managed Care	3,361,994	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,907,565	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: 01/01/15 Ending: 12/31/15

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	2,032	2,221	$ 77,246	$ 34.78	1
2	Assistant Director of Nursing	1,900	2,022	63,647	31.48	2
3	Registered Nurses	3,490	3,613	87,250	24.15	3
4	Licensed Practical Nurses	9,897	10,367	214,372	20.68	4
5	CNAs & Orderlies	50,905	53,088	492,101	9.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,763	7,047	65,882	9.35	10
11	Social Service Workers	11,970	12,389	171,061	13.81	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,082	18,917	183,827	9.72	15
16	Dishwashers					16
17	Maintenance Workers	3,575	3,845	53,131	13.82	17
18	Housekeepers	12,288	12,990	135,028	10.39	18
19	Laundry	3,585	3,767	32,423	8.61	19
20	Administrator	1,957	2,086	102,483	49.13	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,408	8,883	109,860	12.37	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	3,948	4,391	83,684	19.06	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,340	2,340	9,652	4.12	33
34	TOTAL (lines 1 - 33)	141,140	147,966	$ 1,881,647 *	$ 12.72	34

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

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 29,628	01-03	35
36	Medical Director				36
37	Medical Records Consultant	Monthly	1,832	10-03	37
38	Nurse Consultant	Monthly	42,336	10-03	38
39	Pharmacist Consultant	Monthly	10,910	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,243	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Specialized Rehab Consultant	Monthly	24,696	10a-03	47
48	Psych Medical Director	Monthly	48,000	10-03	48
49	TOTAL (lines 35 - 48)		$ 158,645		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: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ruth Huber	Administrator	0	$ 102,483
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 102,483

B. Administrative - Other

Description	Amount
SIR Management - Consulting Fees	$ 245,772
SIR Management - Ancillary Admin. Charges	35,280
SIR Management - Dir. Of Admin Services	42,336
TOTAL (agree to Schedule V, line 17, col. 3)	$ 323,388
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SIR Management	Dir of Regulatory Services	$ 21,168
SIR Management	Bookkeeping	61,740
SIR Management	Dir. of Admissions	24,696
SIR Management	Dir of Financial Service	39,600
Personal Planners	Unemployment Tax Consult	2,339
Pinnacle	Customer Satisfaction	2,784
PayChex	Payroll	11,706
HK Payroll	WOTC Program	4,336
Frost, Ruttenberg & Rothblatt	Accounting	15,075
McGladrey LLC	Accounting	1,455
See Attached	Legal	10,312
See Supplemental Schedule		28,224
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 223,435

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 26,089
Unemployment Compensation Insurance	36,287
FICA Taxes	139,735
Employee Health Insurance	47,645
Employee Meals	6,169
Illinois Municipal Retirement Fund (IMRF)*	
401K Contribution	910
Employment Benefits	7,697
TOTAL (agree to Schedule V, line 22, col.8)	$ 264,531

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	4,208
Health Care Worker Background Check	1,120
(Indicate # of checks performed 112)	
Patient Background Checks 374	3,744
Dues & Subscription	14,215
Licenses & Permits	1,052
Allocated from SIR Management	1,405
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,736

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,214
Allocated from SIR Management	1,019
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,233

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/15 Ending: 12/31/15

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:** 01/01/15 **Ending:** 12/31/15

XX. GENERAL INFORMATION:

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

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

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,437** 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. $ **6,169** 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.