



Facility Name & ID Number Decatur Manor Healthcare

# 0049262 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	43,019	1,425	1,616	46,060	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,019	1,425	1,616	46,060	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.84%

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

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

I. On what date did you start providing long term care at this location? Date started 1/1/2008

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	180,593	24,840	30,310	235,743		235,743	(14,010)	221,733		1
2	Food Purchase		246,671		246,671	(6,315)	240,357	(76)	240,280		2
3	Housekeeping	133,383	28,753		162,136		162,136		162,136		3
4	Laundry	31,840	16,972		48,812		48,812		48,812		4
5	Heat and Other Utilities			93,207	93,207		93,207	(6,966)	86,241		5
6	Maintenance	51,307	38,029	153,268	242,604		242,604	(41,835)	200,769		6
7	Other (specify):*							2,669	2,669		7
8	<b>TOTAL General Services</b>	397,123	355,265	276,785	1,029,173	(6,315)	1,022,859	(60,218)	962,641		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			10,500	10,500		10,500		10,500		9
10	Nursing and Medical Records	984,110	68,388	94,297	1,146,795		1,146,795	(61,991)	1,084,804		10
10a	Therapy			17,640	17,640		17,640	(7,687)	9,953		10a
11	Activities	64,828	15,417	1,231	81,476		81,476		81,476		11
12	Social Services	182,568			182,568		182,568		182,568		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							2,918	2,918		15
16	<b>TOTAL Health Care and Programs</b>	1,231,506	83,805	123,668	1,438,979		1,438,979	(66,760)	1,372,219		16
	<b>C. General Administration</b>										
17	Administrative	93,125		313,084	406,209		406,209	(234,172)	172,037		17
18	Directors Fees										18
19	Professional Services			157,486	157,486	(5,243)	152,243	(91,271)	60,972		19
20	Dues, Fees, Subscriptions & Promotions			42,735	42,735		42,735	(30,841)	11,894		20
21	Clerical & General Office Expenses	108,516	21,944	85,378	215,838		215,838	54,065	269,903		21
22	Employee Benefits & Payroll Taxes			322,374	322,374	6,315	328,689		328,689		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,258	3,258		3,258	660	3,918		24
25	Other Admin. Staff Transportation			12,576	12,576		12,576	(5,301)	7,275		25
26	Insurance-Prop.Liab.Malpractice			95,172	95,172		95,172	1,356	96,528		26
27	Other (specify):*							28,231	28,231		27
28	<b>TOTAL General Administration</b>	201,641	21,944	1,032,063	1,255,648	1,072	1,256,720	(277,273)	979,447		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,830,270	461,014	1,432,516	3,723,800	(5,243)	3,718,557	(404,251)	3,314,306		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number

Decatur Manor Healthcare

#0049262

Report Period Beginning:

01/01/13

Ending:

12/31/13

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			50,845	50,845		50,845	220,230	271,075			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,477	8,477		8,477	192,488	200,965			32
33	Real Estate Taxes					5,243	5,243	35,735	40,978			33
34	Rent-Facility & Grounds			408,000	408,000		408,000	(408,000)				34
35	Rent-Equipment & Vehicles			4,200	4,200		4,200	4,214	8,414			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			471,522	471,522	5,243	476,765	44,667	521,432			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,391		1,391		1,391		1,391			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			201,454	201,454		201,454		201,454			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		1,391	201,454	202,845		202,845		202,845			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,830,270	462,405	2,105,492	4,398,167		4,398,167	(359,584)	4,038,583			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Decatur Manor Healthcare

# 0049262

Report Period Beginning:

01/01/13

Ending:

12/31/13

**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.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(8,440)	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	14,269	30		9
10	Interest and Other Investment Income	(30,115)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(76)	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	(5,250)	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	(9,099)	21		24
25	Fund Raising, Advertising and Promotional	(5,135)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(440)	20		28
29	Other-Attach Schedule	(124,333)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (168,619)</b>		<b>\$</b>	<b>30</b>

**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	2	
		<b>Amount</b>	<b>Reference</b>	
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)	(190,965)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (190,965)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (359,584)</b>		<b>37</b>

\*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	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

<b>BHF USE ONLY</b>					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Decatur Manor Healthcare

ID# 0049262

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Misc. Income	\$ (165)	21	1
2	Dues & Subscriptions - PAC	(20,333)	20	2
3	Veterans Pres. Drugs	(38,909)	10	3
4	Bank Fees	(6,130)	21	4
5	Theft & Damage	(150)	21	5
6	State Replacement Tax	(6,347)	21	6
7	Capitalized R&M	(33,163)	06	7
8	Building Co. - Amortization	(1,456)	36	8
9	Building Co. - Filing Fees	(250)	21	9
10	Building Co. - Office Expenses	(47)	21	10
11	Non Allowable Legal	(3,891)	19	11
12	Non Allowable Travel	(12,000)	25	12
13	Vending Income	(1,492)	1	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	<b>Total</b>	(124,333)	49

Decatur Manor Healthcare

ID# 0049262

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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	<b>Total</b>		0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Decatur Manor Healthcare# 0049262

Report Period Beginning:

01/01/13

Ending:

12/31/13

## 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	(1,492)			(12,518)								(14,010)	1
2	Food Purchase	(76)											(76)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(8,440)			1,474								(6,966)	5
6	Maintenance	(33,163)		(10,806)	2,134								(41,835)	6
7	Other (specify):*			424	2,245								2,669	7
8	<b>TOTAL General Services</b>	<b>(43,171)</b>		<b>(10,382)</b>	<b>(6,665)</b>								<b>(60,218)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(38,909)		(28,683)	5,601								(61,991)	10
10a	Therapy				(7,687)								(7,687)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			863	2,055								2,918	15
16	<b>TOTAL Health Care and Programs</b>	<b>(38,909)</b>		<b>(27,820)</b>	<b>(31)</b>								<b>(66,760)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(294,121)	59,949								(234,172)	17
18	Directors Fees													18
19	Professional Services	(3,891)		(98,225)	10,845								(91,271)	19
20	Fees, Subscriptions & Promotions	(31,158)		317									(30,841)	20
21	Clerical & General Office Expenses	(22,188)	297	75,906	50								54,065	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			660									660	24
25	Other Admin. Staff Transportation	(12,000)		6,699									(5,301)	25
26	Insurance-Prop.Liab.Malpractice			1,251	105								1,356	26
27	Other (specify):*			16,318	11,913								28,231	27
28	<b>TOTAL General Administration</b>	<b>(69,237)</b>	<b>297</b>	<b>(291,195)</b>	<b>82,862</b>								<b>(277,273)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(151,317)</b>	<b>297</b>	<b>(329,397)</b>	<b>76,166</b>								<b>(404,251)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Decatur Manor Healthcare

# 0049262

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	14,269	201,515		4,446								220,230	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(30,115)	229,412	(11,438)	4,629								192,488	32
33	Real Estate Taxes		31,468		4,267								35,735	33
34	Rent-Facility & Grounds		(408,000)										(408,000)	34
35	Rent-Equipment & Vehicles			4,214									4,214	35
36	Other (specify):*	(1,456)	1,456											36
37	<b>TOTAL Ownership</b>	<b>(17,302)</b>	<b>55,851</b>	<b>(7,224)</b>	<b>13,342</b>								<b>44,667</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>													<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(168,619)</b>	<b>56,148</b>	<b>(336,621)</b>	<b>89,508</b>								<b>(359,584)</b>	<b>45</b>

**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		Building Co.
				Decatur Healthcare Estates		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 408,000	Decatur Healthcare Estates	100.00%	\$	\$(408,000)	1
2	V	36 Amortization-Loan Fees		Decatur Healthcare Estates	100.00%	1,456	1,456	2
3	V	30 Depreciation		Decatur Healthcare Estates	100.00%	201,515	201,515	3
4	V	21 Filing Fees		Decatur Healthcare Estates	100.00%	250	250	4
5	V	32 Interest Expense		Decatur Healthcare Estates	100.00%	229,518	229,518	5
6	V	21 Office		Decatur Healthcare Estates	100.00%	47	47	6
7	V	33 Real Estate Taxes	16,692	Decatur Healthcare Estates	100.00%	48,160	31,468	7
8	V	32 Interest Income	106	Decatur Healthcare Estates	100.00%		(106)	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 424,798			\$ 480,946	\$ * 56,148	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 REPAIRS AND MAINT.	\$ 17,640	S.I.R. MANAGEMENT, INC.	100.00%	\$ 6,834	\$ (10,806)
16	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	424	424
17	V	10 NURSING	35,280	S.I.R. MANAGEMENT, INC.	100.00%	6,597	(28,683)
18	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	863	863
19	V	19 PROFESSIONAL FEES	111,852	S.I.R. MANAGEMENT, INC.	100.00%	10,775	(101,077)
20	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	317	317
21	V	21 CLERICAL & GENERAL	35,280	S.I.R. MANAGEMENT, INC.	100.00%	37,710	2,430
22	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	660	660
23	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	6,699	6,699
24	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,251	1,251
25	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	5,301	5,301
26	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(11,438)	(11,438)
27	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	4,214	4,214
28	V						
29	V	17 ADMINISTRATIVE	313,084	S.I.R. MANAGEMENT, INC.	100.00%	18,963	(294,121)
30	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	2,852	2,852
31	V	21 CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	73,476	73,476
32	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	11,017	11,017
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 513,136			\$ 176,515	\$ * (336,621)

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1	DIETARY SALARIES	\$ 17,640	S.I.R. MANAGEMENT, INC.	100.00%	\$ 5,122	\$ (12,518)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	674	674	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	5,601	5,601	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	730	730	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	59,949	59,949	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	10,802	10,802	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	11,913	11,913	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	17,640	S.I.R. MANAGEMENT, INC.	100.00%	9,953	(7,687)	24
25	V	15	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,325	1,325	25
26	V								26
27	V	6	MAINTENANCE SALARIES	8,970	S.I.R. MANAGEMENT, INC.	100.00%	10,554	1,584	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,571	1,571	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	1,474	1,474	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	550	550	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	43	43	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	50	50	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	105	105	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	4,446	4,446	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	4,629	4,629	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	4,267	4,267	37
38	V								38
39	Total		\$ 44,250				\$ 133,758	\$ * 89,508	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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	<b>Total</b>		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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	<b>Total</b>		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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	<b>Total</b>		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	26.398%	ALBANY CARE INC	EVANSTON	DECATUR HEALTHCARE ESTA	LINCOLNWOOD	BUILDING CO.	1
2	BARRISH GROUP LIMITED	8.799%	APPLEWOOD REHABILITATION CENTER,LLC	MATTESON	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	2
3	BRYAN BARRISH TRUST	8.799%	BRYN MAWR CARE INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	FAY CHIN	1.342%	COLUMBUS PARK NURSING & REHABILITATION CENTER, INC.	CHICAGO				4
5	JEFF ORAVEC	1.342%	ELMWOOD CARE, INC.	ELMWOOD PARK				5
6	LOUISE BERGTHOLD	3.356%	FAIRVIEW NURSING PLAZA, INC.	ROCKFORD				6
7	LYNN ETHELL	1.342%	GREENWOOD CARE, INC.	EVANSTON				7
8	NENITA GUZMAN	1.342%	MAPLEWOOD CARE, INC.	ELGIN				8
9	PATRICIA MCDIARMID	1.342%	NEIGHBORS REHABILITATION CENTER,LLC	BYRON				9
10	RALPH GESUALDO	8.799%	REGENCY REHABILITATION CENTER,LLC	NILES				10
11	RALPH GESUALDO CHILDREN'S TRUST	8.799%	ROCK ISLAND NURSING & REHAB CENTER,LLC	ROCK ISLAND				11
12	RONALD NUNZIATO JR.	2.685%	WILSON CARE, INC.	CHICAGO				12
13	THOMAS WINTER	6.711%	WESLEY REHABILITATION CENTER	AUBURN, IN				13
14	UNITED TRUST #1	4.400%						14
15	UNITED TRUST #2	4.400%						15
16	KIM SHELTON	1.342%						16
17	L.G. TRUST	4.400%						17
18	B.G. TRUST	4.400%						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

SEE ACCOUNTANTS' COMPILATION REPORT

**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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/13 Ending: 12/31/13

## 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Tom Winter	Shareholder	Administrative	6.71%	See Attached	3.35	5.58%	Alloc. Salary	\$ 11,183	17-07	1
2	Louise Bergthold	Shareholder	Administrative	3.36%	See Attached	3.35	5.58%	Alloc. Salary	11,183	17-07	2
3	Patricia Mediarmid	Shareholder	Administrative	1.34%	See Attached	2.8	5.60%	Alloc. Salary	7,672	17-07	3
4	Ronald Nunziatio	Shareholder	Administrative	2.68%	See Attached	2.24	5.60%	Alloc. Salary	11,183	17-07	4
5	Jeff Oravec	Shareholder	Administrative	1.34%	See Attached	2.24	5.60%	Alloc. Salary	7,781	17-07	5
6	Fay Chin	Shareholder	Nursing	1.34%	See Attached	2.24	5.60%	Alloc. Salary	5,601	10-07	6
7	Nenita Guzman	Shareholder	Dietary	1.34%	See Attached	2.8	5.60%	Alloc. Salary	5,122	01-07	7
8	Kim Shelton	Shareholder	Clerical	1.34%	See Attached	2.24	5.60%	Alloc. Salary	4,023	21-07	8
9	Andrew Chin	Relative	Clerical	0%	See Attached	2.24	5.60%	Alloc. Salary	4,082	21-07	9
10	Matthew Winter	Relative	Clerical	0%	See Attached	0.34	5.57%	Alloc. Salary	177	21-07	10
11	Kirsten Barrish	Relative	Clerical	0%	See Attached	2.8	5.60%	Alloc. Salary	2,818	21-07	11
12	See Page 7-Supplemental for additional owner and related compensation								25,862		12
13								TOTAL	\$ 96,687		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Decatur Manor Healthcare

# 0049262

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Decatur Manor Healthcare

# 0049262

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	REPAIRS AND MAINT.	PATIENT DAYS	823,778	14	\$ 122,226	\$ 54,106	46,060	\$ 6,834	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	823,778	14	7,581	46,060	46,060	424	2
3	10	NURSING	PATIENT DAYS	823,778	14	117,990	117,990	46,060	6,597	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	823,778	14	15,435	46,060	46,060	863	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	823,778	14	192,718	109,921	46,060	10,775	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	823,778	14	5,665	46,060	46,060	317	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	823,778	14	674,435	608,408	46,060	37,710	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	823,778	14	11,805	46,060	46,060	660	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	823,778	14	119,815	46,060	46,060	6,699	9
10	26	INSURANCE	PATIENT DAYS	823,778	14	22,368	46,060	46,060	1,251	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	823,778	14	94,799	46,060	46,060	5,301	11
12	32	INTEREST	PATIENT DAYS	823,778	14	(204,568)	46,060	46,060	(11,438)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	823,778	14	75,364	46,060	46,060	4,214	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	823,778	14	339,156	339,156	46,060	18,963	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	823,778	14	51,011	46,060	46,060	2,852	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	823,778	14	1,314,118	1,179,981	46,060	73,476	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	823,778	14	197,046	46,060	46,060	11,017	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,156,964	\$ 2,409,562		\$ 176,515	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Decatur Manor Healthcare

# 0049262

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY SALARIES	PATIENT DAYS	823,778	14	\$ 91,605	\$ 91,605	46,060	\$ 5,122	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	823,778	14	12,049	46,060	674	2	
3	10	NURSING SALARIES	PATIENT DAYS	823,778	14	100,168	100,168	46,060	5,601	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	823,778	14	13,047	46,060	730	4	
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	823,778	14	1,072,182	1,072,182	46,060	59,949	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	823,778	14	193,200	46,060	10,802	6	
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	823,778	14	213,069	46,060	11,913	7	
8									8	
9									9	
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	293,544	14	165,622	165,622	17,640	9,953	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	293,544	14	22,047	17,640	1,325	11	
12									12	
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	378,109	14	444,871	444,871	8,970	10,554	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	378,109	14	66,242	8,970	1,571	14	
15									15	
16	5	UTILITIES	ALLOCATED SQ FT	12,879	14	26,365	720	1,474	16	
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	14	9,845	720	550	17	
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	14	768	720	43	18	
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	14	896	720	50	19	
20	26	INSURANCE	ALLOCATED SQ FT	12,879	14	1,870	720	105	20	
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	14	79,536	720	4,446	21	
22	32	INTEREST	ALLOCATED SQ FT	12,879	14	82,793	720	4,629	22	
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	14	76,319	720	4,267	23	
24									24	
25	TOTALS					\$ 2,672,494	\$ 1,874,447	\$ 133,758	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Decatur Manor Healthcare

# 0049262 Report Period Beginning: 01/01/13 Ending: 12/31/13

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Decatur Manor Healthcare

# 0049262

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Decatur Manor Healthcare

# 0049262

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Decatur Manor Healthcare

# 0049262

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Decatur Manor Healthcare

# 0049262

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Decatur Manor Healthcare

# 0049262

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Decatur Manor Healthcare

# 0049262

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

**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	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	Centure Bank		X	Mortgage			\$	\$ 3,699,566			\$ 229,518	1					
2												2					
3												3					
4												4					
5												5					
<b>Working Capital</b>																	
6	Lake Forest Bank & Trust		X	Line of Credit		4/2008		450,000		0.0500	8,047	6					
7	Hyundai Finance		X	Note Payable	\$299.45	8/26/2010	16,300	5,790	8/26/2015	3.9000	296	7					
8	See Supplemental Schedule										4,762	8					
9	<b>TOTAL Facility Related</b>				\$299.45		\$ 16,300	\$ 4,155,356			\$ 242,623	9					
<b>B. Non-Facility Related*</b>																	
10	Interest Income		X								(30,115)	10					
11	Interest Income - Bldg Co		X								(106)	11					
12	Alloc from S.L.R. Mngmnt	X									(11,438)	12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (41,659)	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 16,300	\$ 4,155,356			\$ 200,964	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.) 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:

01/01/13

Ending:

12/31/13

**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		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
6											6							
7	<b>TOTAL Long-Term</b>										7							
<b>Working Capital</b>																		
8	GMAC		X	Note Payable		\$	\$			\$	133							
9	Allocated from S.I.R. Mngmnt	X									4,629							
10											10							
11											11							
12											12							
13											13							
14	<b>TOTAL Working Capital</b>										14							
<b>B. Non-Facility Related*</b>																		
15						\$	\$			\$	15							
16											16							
17											17							
18											18							
19											19							
20	<b>TOTAL Non-Facility Related</b>										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.)

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2012 report.		\$	<b>63,000</b>		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.)		\$	<b>50,575</b>		2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(12,425)</b>		3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>48,160</b>		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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<b>5,243</b>		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. <b>TOTAL REFUND \$ 15,365 For 2011 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>40,978</b>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2008	<u>73,507</u>			8
	2009	<u>74,716</u>			9
	2010	<u>75,972</u>			10
	2011	<u>60,024</u>			11
	2012	<u>46,308</u>			12
<b>2013 Accrual - \$46,308 x 1.04 = \$48,160</b>					
<b>Allocated from S.I.R. Managment - \$4,267</b>					
<b>FOR BHF USE ONLY</b>					
	13	FROM R. E. TAX STATEMENT FOR 2012	\$		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.**

SEE ACCOUNTANTS' COMPILATION REPORT

## 2012 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 2012 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 2012.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>07-07-34-351-013</u>	<u>Long Term Care Property</u>	\$ <u>46,307.70</u>	\$ <u>46,307.70</u>
2. <u>See Attached</u>	<u>Home Office Allocation</u>	\$ <u>106,516.99</u>	\$ <u>4,663.56</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>152,824.69</u></u>	\$ <u><u>50,971.26</u></u>

**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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

**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.**



4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ _____	\$ _____

**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.

**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  (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?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (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  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	<u>Facility</u>	<u>130,680</u>	<u>2008</u>	<u>\$ 100,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>130,680</b>		<b>\$ 100,000</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	147		2008	1976	\$ 2,902,875	\$ 95,605	35	\$ 82,939	\$ (12,666)	\$ 486,026	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		2008		11,477		20	1,148	1,148	6,444	9
10	Various		2009		26,920		20	1,346	1,346	5,985	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											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

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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		749,210	43,387		37,772	(5,615)	156,308	67
68		101,312	2,817		3,957	1,140	45,752	68
69			50,845			(50,845)		69
70		\$ 3,791,794	\$ 192,654		\$ 127,162	\$ (65,492)	\$ 700,514	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Decatur Manor Healthcare

# 0049262

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,791,794	\$ 192,654		\$ 127,162	\$ (65,492)	\$ 700,514	1
2	Bypass Doors	2010	3,100		20	620	620	2,480	2
3	Drop Ceiling	2010	9,585		20	959	959	3,275	3
4	Garage Doors	2010	2,500		20	500	500	1,542	4
5	Replace Window	2010	3,087		20	154	154	617	5
6	Door Replacement	2010	4,422		20	221	221	866	6
7	Roof Repair	2010	3,475		20	174	174	565	7
8	Hvac- Air Unit	2011	5,545		20	555	555	1,386	8
9	Security Camera System	2011	9,845		20	492	492	1,108	9
10	Power Generator	2011	54,850		20	2,743	2,743	5,942	10
11	Replace Window	2011	2,919		20	146	146	389	11
12	Replace Temp Valves	2011	2,825		20	141	141	377	12
13	Install Pipe Line	2011	4,953		20	248	248	537	13
14	Pull Station Covers	2011	2,994		20	150	150	399	14
15	Floor Registers	2012	2,699		20	135	135	270	15
16	Custom Cabinets	2012	8,000		20	400	400	767	16
17	Cabinetry-Reception	2012	2,900		20	145	145	278	17
18	Nurse Station	2012	19,800		20	990	990	1,320	18
19	Electrical Wiring	2012	3,805		20	190	190	254	19
20	Emergency Lights	2012	3,605		20	180	180	210	20
21	Furnace	2012	5,362		20	268	268	313	21
22	Lobby Window Treatment	2012	2,705		20	135	135	248	22
23	Retile Facility	2012	95,887		20	4,794	4,794	7,991	23
24	Retile Facility	2012	94,518		20	4,726	4,726	7,877	24
25	Sprinkler Heads	2012	3,832		20	192	192	255	25
26	Retaining Wall & Landscaping	2012	10,000		20	500	500	708	26
27	Magnetic Door Locks	2013	3,401		20	170	170	170	27
28	Run New Hot Water Lines - Breakroom & Kitchen	2013	7,237		20	362	362	362	28
29	Weld Metal Door And Frames With Existing Wall Anchors	2013	5,320		20	266	266	266	29
30	Relocate Phn Ln, Install Rcptcls, Door Magnets In Staff Desk, Mai	2013	2,906		20	145	145	145	30
31	Painting 12 Rooms In D Hallway	2013	3,600		20	180	180	180	31
32	Painting 12 Rooms In E Hallway	2013	3,600		20	180	180	180	32
33	Painting 12 Rooms In G Hallway	2013	3,600		20	180	180	180	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,184,671	\$ 192,654		\$ 148,402	\$ (44,252)	\$ 741,970	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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		\$ 4,184,671	\$ 192,654		\$ 148,402	\$ (44,252)	\$ 741,970	1
2	Seal And Stripe Parking Lot	2013	3,300		20	165	165	165	2
3	Painting 12 Rooms In C Hallway	2013	3,600		20	180	180	180	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)		\$ 4,191,571	\$ 192,654		\$ 148,747	\$ (43,907)	\$ 742,315	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,191,571	\$ 192,654		\$ 148,747	\$ (43,907)	\$ 742,315	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)	\$ 4,191,571	\$ 192,654		\$ 148,747	\$ (43,907)	\$ 742,315	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12D, Carried Forward		\$ 4,191,571	\$ 192,654		\$ 148,747	\$ (43,907)	\$ 742,315	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)		\$ 4,191,571	\$ 192,654		\$ 148,747	\$ (43,907)	\$ 742,315	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Building Company Information</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3									3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements</b>								8
9	Roof	2008	83,141	5,543	20	4,157	(1,386)	18,476	9
10	Hand Rails	2008	41,519	4,152	20	2,076	(2,076)	8,996	10
11	Demolition, Framing, Plumbing, Heating...	2008	71,200	3,560	20	3,560		16,020	11
12	Demolition, Electrical, Plumbing, Painting, Flooring....	2008	455,946	22,797	20	22,797		94,988	12
13	Painting Doors	2008	7,840	784	20	392	(392)	1,633	13
14	Draperies	2008	35,206	3,521	20	1,760	(1,761)	7,105	14
15	Trane A/C Unit	2010	12,989	649	20	649		1,947	15
16	Fire Alarm	2010	7,539	377	20	377		1,131	16
17	Rooftop Heat Exchanger	2010	9,900	495	20	495		1,485	17
18	Satellite TV Install	2010	11,930	909	20	909		2,727	18
19	Paving Parking Lot	2010	12,000	600	20	600		1,800	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

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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:

01/01/13

Ending:

12/31/13

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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
31								31
32								32
33								33
34	TOTAL (12F & 12G lines 1 thru 33)	\$ 749,210	\$ 43,387		\$ 37,772	\$ (5,615)	\$ 156,308	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Related Party Information</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3	Allocated from S.I.R. Management	2009	13,976		39	358	358	1,448	3
4	Allocated - S.I.R Properties - S.I.R. Management	1993	25,306	803	35	723	(80)	14,822	4
5									5
6									6
7									7
8	<b>Leasehold Information</b>								8
9	Allocated from S.I.R. Management	1994	20		20			20	9
10	Allocated from S.I.R. Management	1995	147		20	7	7	135	10
11	Allocated from S.I.R. Management	1997	9,859	221	20	481	260	8,251	11
12	Allocated from S.I.R. Management	1999	775		20	39	39	552	12
13	Allocated from S.I.R. Management	2000	915		20	46	46	620	13
14	Allocated from S.I.R. Management	2007	2,941	201	20	147	(54)	911	14
15	Allocated from S.I.R. Management	2008	8,104	774	20	511	(263)	2,985	15
16	Allocated from S.I.R. Management	2009	20,137	184	20	1,007	823	4,274	16
17	Allocated from S.I.R. Management	2011	498	50	20	50		120	17
18	Allocated from S.I.R. Management	2012	1,594	80	20	79	(1)	112	18
19	Allocated from S.I.R. Management	1993	6,416	179	20	55	(124)	6,416	19
20									20
21	Allocated - S.I.R Properties - S.I.R. Management	2012	1,550	214	20	11	(203)	12	21
22	Allocated - S.I.R Properties - S.I.R. Management	2010	1,527		20	76	76	255	22
23	Allocated - S.I.R Properties - S.I.R. Management	2009	1,519	68	20	76	8	365	23
24	Allocated - S.I.R Properties - S.I.R. Management	2007	443	35	20	22	(13)	155	24
25	Allocated - S.I.R Properties - S.I.R. Management	2002	100		20	5	5	58	25
26	Allocated - S.I.R Properties - S.I.R. Management	1999	3,207		20	160	160	2,325	26
27	Allocated - S.I.R Properties - S.I.R. Management	1998	1,532		20	77	77	1,188	27
28	Allocated - S.I.R Properties - S.I.R. Management	1997	95		20	5	5	83	28
29	Allocated - S.I.R Properties - S.I.R. Management	1994	241	6	20	12	6	235	29
30	Allocated - S.I.R Properties - S.I.R. Management	1993	410	2	20	10	8	410	30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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
31								31
32								32
33								33
34	TOTAL (12H & 12I lines 1 thru 33)	\$ 101,312	\$ 2,817		\$ 3,957	\$ 1,140	\$ 45,752	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 1,167,079	\$ 63,948	\$ 116,580	\$ 52,632	10	\$ 544,967	71
72	Current Year Purchases	15,977		1,493	1,493	10	1,493	72
73	Fully Depreciated Assets	22,550		17	17	10	22,550	73
74								74
75	TOTALS	\$ 1,205,606	\$ 63,948	\$ 118,090	\$ 54,142		\$ 569,009	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	\$	\$ 4,005	\$ 4,005	5	\$ 30,038	76
77		Allocated from S.I.R. Management	2013	1,965	206	235	29	5	922	77
78										78
79										79
80	TOTALS			\$ 32,003	\$ 206	\$ 4,240	\$ 4,034		\$ 30,960	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)	\$ 5,529,180	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 256,808	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 271,077	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 14,269	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,342,284	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	Construction in Progress	\$ 1,800	92
93			93
94			94
95		\$ 1,800	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.

SEE ACCOUNTANTS' COMPILATION REPORT

**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

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. \_\_\_\_\_ /2014                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2015                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2016                      \$ \_\_\_\_\_

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: \_\_\_\_\_ \*

**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: \$ 8,417 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			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/13 Ending: 12/31/13  
**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.)**

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
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)	
<b>TOTAL TRAINED</b>	

- (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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			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 prescripts													9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															12
13	Other (specify): <b>See Supplemental</b>										<b>1,391</b>				<b>1,391</b>	13
14	<b>TOTAL</b>			\$		\$		\$		<b>1,391</b>		\$		<b>1,391</b>		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Decatur Manor Healthcare

# 0049262

Report Period Beginning: 01/01/13

Ending:

12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 52,517	\$ 96,319	1
2	Cash-Patient Deposits	32,086	32,086	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	848,955	848,955	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,540	15,540	6
7	Other Prepaid Expenses	1,826	1,826	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 950,924</b>	<b>\$ 994,726</b>	<b>10</b>
<b>B. Long-Term Assets</b>				
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	330,045	1,001,691	15
16	Equipment, at Historical Cost	281,464	1,340,503	16
17	Accumulated Depreciation (book methods)	(177,076)	(1,324,475)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		52,137	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(2,791)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	1,096,879	1,579,980	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 1,531,312</b>	<b>\$ 5,649,920</b>	<b>24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 2,482,236</b>	<b>\$ 6,644,646</b>	<b>25</b>

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 138,545	\$ 138,545	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	32,131	32,131	28
29	Short-Term Notes Payable	450,000	450,000	29
30	Accrued Salaries Payable	118,397	118,397	30
31	Accrued Taxes Payable (excluding real estate taxes)	24,919	24,919	31
32	Accrued Real Estate Taxes(Sch.IX-B)		48,160	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>	28,798	28,798	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	<b>\$ 792,790</b>	<b>\$ 840,950</b>	<b>38</b>
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	5,790	5,790	39
40	Mortgage Payable		3,699,566	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43			63,786	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	<b>\$ 5,790</b>	<b>\$ 3,769,142</b>	<b>45</b>
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	<b>\$ 798,580</b>	<b>\$ 4,610,092</b>	<b>46</b>
47	<b>TOTAL EQUITY(page 18, line 24)</b>	<b>\$ 1,683,656</b>	<b>\$ 2,034,554</b>	<b>47</b>
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	<b>\$ 2,482,236</b>	<b>\$ 6,644,646</b>	<b>48</b>

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,476,763	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,476,763	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	527,243	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	(320,350)	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)	\$ 206,893	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 1,683,656	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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.

		1		
I. Revenue		Amount		
<b>A. Inpatient Care</b>				
1	Gross Revenue -- All Levels of Care	\$ 4,853,257	1	
2	Discounts and Allowances for all Levels	(14,129)	2	
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,839,128	3	
<b>B. Ancillary Revenue</b>				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy		6	
7	Oxygen		7	
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8	
<b>C. Other Operating Revenue</b>				
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	171	13	
14	Non-Patient Meals		14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	38,377	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 38,548	23	
<b>D. Non-Operating Revenue</b>				
24	Contributions		24	
25	Interest and Other Investment Income***	30,115	25	
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 30,115	26	
<b>E. Other Revenue (specify):****</b>				
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27	
28	<u>See Supplemental Schedule</u>	17,619	28	
28a			28a	
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 17,619	29	
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,925,410	30	

		2		
II. Expenses		Amount		
<b>A. Operating Expenses</b>				
31	General Services	1,029,173	31	
32	Health Care	1,438,979	32	
33	General Administration	1,255,648	33	
<b>B. Capital Expense</b>				
34	Ownership	471,522	34	
<b>C. Ancillary Expense</b>				
35	Special Cost Centers	1,391	35	
36	Provider Participation Fee	201,454	36	
<b>D. Other Expenses (specify):</b>				
37			37	
38			38	
39			39	
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,398,167	40	
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	527,243	41	
42	<b>Income Taxes</b>		42	
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 527,243	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,482,668	44
45	Private Pay - Net Inpatient Revenue	163,460	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Veterans</u>	193,000	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 4,839,128	49

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

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

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

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

**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name & ID Number Decatur Manor Healthcare

# 0049262

Report Period Beginning: 01/01/13

Ending: 12/31/13

12/31/13

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,241	2,421	\$ 84,347	\$ 34.84	1
2	Assistant Director of Nursing	1,829	1,976	55,478	28.08	2
3	Registered Nurses	1,834	2,009	46,957	23.37	3
4	Licensed Practical Nurses	11,695	12,414	244,072	19.66	4
5	CNAs & Orderlies	49,463	51,658	473,677	9.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,692	1,834	23,523	12.83	9
10	Activity Assistants	4,726	4,838	41,305	8.54	10
11	Social Service Workers	13,077	13,890	182,568	13.14	11
12	Dietician					12
13	Food Service Supervisor	1,969	2,086	35,678	17.10	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,285	16,764	144,915	8.64	15
16	Dishwashers					16
17	Maintenance Workers	3,755	3,962	51,307	12.95	17
18	Housekeepers	12,780	13,475	133,383	9.90	18
19	Laundry	3,661	3,797	31,840	8.39	19
20	Administrator	1,941	2,086	93,125	44.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,134	8,596	108,516	12.62	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	4,060	4,365	79,579	18.23	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	139,142	146,171	\$ 1,830,270 *	\$ 12.52	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 30,310	01-03	35
36	Medical Director	Monthly	10,500	09-03	36
37	Medical Records Consultant	Monthly	1,275	10-03	37
38	Nurse Consultant	Monthly	35,280	10-03	38
39	Pharmacist Consultant	Monthly	9,742	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Quarterly	1,231	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Speialized Rehab Consultant	Monthly	17,640	10a-03	47
48	Psych Medical Director	Monthly	48,000	10-03	48
49	TOTAL (lines 35 - 48)		\$ 153,978		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Ruth Huber	Administrator	0	\$ 93,125	Workers' Compensation Insurance	\$ 21,550	IDPH License Fee	\$ 1,992	
				Unemployment Compensation Insurance	101,977	Advertising: Employee Recruitment	3,557	
				FICA Taxes	136,371	Health Care Worker Background Check		
				Employee Health Insurance	58,706	(Indicate # of checks performed <u>391</u> )	3,917	
				Employee Meals	6,315	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	978	
				Other Employee Benefits	3,770	Licenses & Permits	1,132	
						Alloc. From S.I.R. Management	317	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 93,125					
B. Administrative - Other								
Description			Amount					
SIR Management - Director of Admin Services			\$ 35,280				Less: Public Relations Expense ( )	
SIR Management - Ancillary Admin. Charges			35,280				Non-allowable advertising ( )	
SIR Management - Management Fees			242,524				Yellow page advertising ( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 313,084	TOTAL (agree to Schedule V, line 22, col.8)			\$ 328,689	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
HK Payroll Services	WOTC Consulting		\$ 1,314				Out-of-State Travel	\$
Personnel Planners	Unemployment Consulting		1,875					
Frost, Ruttenberg & Rothblatt, PC	Accounting		12,140				In-State Travel	
SIR Management	Accounting		36,000					
SIR Management	Bookkeeping		58,212					
SIR Management	Dir. Of Regulatory Services		17,640				Seminar Expense	3,258
Various	Legal		23,710				Allocated from S.I.R. Management	660
Adj on Page 5A	Legal		3,891					
Pinnacle	Customer Satisfaction		2,703				Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 157,485	TOTAL			\$ 3,918	

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

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	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	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Decatur Manor Healthcare

# 0049262

Report Period Beginning:

01/01/13

Ending:

12/31/13

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 - \$20,748
- (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. \$ None Line N/A
- (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. \$ 201,454  
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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. \$ 6,315 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) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.