

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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

I. IDPH License ID Number: <u>0049262</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Decatur Manor Healthcare</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/11</u> to <u>12/31/11</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>1016 W. Pershing Rd.</u> <u>Decatur</u> <u>62526</u>																									
Number City Zip Code																									
County: <u>Macon</u>																									
Telephone Number: <u>(217) 875-0833</u> Fax # <u>(217) 875-6851</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Cary Drazner, C.P.A.</u></td></tr><tr><td>(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td></tr><tr><td>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Print Name and Title) <u>Cary Drazner, C.P.A.</u>	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630												
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Date of Initial License for Current Owners: <u>01/00/00</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY,NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY,NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☒ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☒ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236-1111</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Decatur Manor Healthcare

0049262 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	43,523	847	1,386	45,756	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,523	847	1,386	45,756	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.28%

D. How many bed-hold days during this year were paid by the Department? 350 (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 _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	
	A. General Services											
1	Dietary	196,596	24,365	31,562	252,523		252,523	(12,646)	239,877			1
2	Food Purchase		238,099		238,099	(6,169)	231,931	(44)	231,887			2
3	Housekeeping	136,225	40,846		177,071		177,071	(387)	176,684			3
4	Laundry	31,778	11,709		43,487		43,487	(351)	43,136			4
5	Heat and Other Utilities			112,850	112,850		112,850	1,563	114,413			5
6	Maintenance	41,826	34,236	106,200	182,262		182,262	(19,071)	163,191			6
7	Other (specify):*							2,283	2,283			7
8	TOTAL General Services	406,425	349,255	250,612	1,006,292	(6,169)	1,000,124	(28,653)	971,470			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,022,206	80,415	92,661	1,195,282		1,195,282	(60,212)	1,135,070			10
10a	Therapy			17,640	17,640		17,640	(10,762)	6,878			10a
11	Activities	81,053	16,081	976	98,110		98,110		98,110			11
12	Social Services	155,302			155,302		155,302		155,302			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							3,889	3,889			15
16	TOTAL Health Care and Programs	1,258,561	96,496	111,277	1,466,334		1,466,334	(67,084)	1,399,250			16
	C. General Administration											
17	Administrative	91,881		294,373	386,254		386,254	(223,084)	163,170			17
18	Directors Fees											18
19	Professional Services			151,847	151,847	(7,350)	144,497	(104,710)	39,787			19
20	Dues, Fees, Subscriptions & Promotions			43,239	43,239		43,239	(25,129)	18,110			20
21	Clerical & General Office Expenses	105,399	16,376	72,456	194,231		194,231	57,027	251,258			21
22	Employee Benefits & Payroll Taxes			304,791	304,791	6,169	310,960		310,960			22
23	Inservice Training & Education											23
24	Travel and Seminar			993	993		993	475	1,468			24
25	Other Admin. Staff Transportation			16,175	16,175		16,175	6,543	22,718			25
26	Insurance-Prop.Liab.Malpractice			78,181	78,181		78,181	1,071	79,252			26
27	Other (specify):*							29,153	29,153			27
28	TOTAL General Administration	197,280	16,376	962,055	1,175,711	(1,182)	1,174,529	(258,654)	915,875			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,862,266	462,127	1,323,944	3,648,337	(7,350)	3,640,987	(354,391)	3,286,595			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			27,017	27,017		27,017	218,102	245,119			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			16,326	16,326		16,326	248,706	265,032			32
33	Real Estate Taxes			78,000	78,000	7,350	85,350	4,418	89,768			33
34	Rent-Facility & Grounds			372,000	372,000		372,000	(372,000)				34
35	Rent-Equipment & Vehicles			6,645	6,645		6,645	4,762	11,407			35
36	Other (specify):*							0	0			36
37	TOTAL Ownership			499,988	499,988	7,350	507,338	103,988	611,326			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			80,483	80,483		80,483		80,483			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			80,483	80,483		80,483		80,483			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,862,266	462,127	1,904,415	4,228,808		4,228,808	(250,404)	3,978,404			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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	11,201	30		9
10	Interest and Other Investment Income	(32,316)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(44)	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	(3,600)	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	(1,535)	21		24
25	Fund Raising, Advertising and Promotional	(10,664)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(79,774)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (119,732)		\$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(130,671)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (130,671)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (250,404)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Decatur Manor Healthcare

	ID#	0049262
Report Period Beginning:		01/01/11
Ending:		12/31/11

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Misc. Income	\$ (97)	21	1
2	Cost of Presc. Drugs - Veterans	(39,052)	10	2
3	Purchased Services - Veterans	(232)	10	3
4	Bank Fees	(5,895)	21	4
5	Theft & Damage	(262)	21	5
6	Cable TV	(207)	05	6
7	Non Allowable Legal	(5,515)	19	7
8	Building Co - Filing Fees	(250)	21	8
9	Building Co - Professional Fees	(5,118)	19	9
10	Building Co - Amortization	(2,347)	36	10
11	Capitalized R&M	(13,691)	06	11
12	Alliance for Living PAC Dues	(11,351)	20	12
13	Additional R&M	4,551	6	13
14	License&Fees - Annual Report Fee	(309)	20	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
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31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(79,774)		49

Decatur Manor Healthcare

	ID#	0049262
Report Period Beginning:		01/01/11
Ending:		12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
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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				49

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ 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	\$ 372,000	Decatur Healthcare Estates	100.00%	\$	\$ (372,000)	1
2	V	33	Rental Taxes	78,000	Decatur Healthcare Estates	100.00%		(78,000)	2
3	V	36	Amortization - Loan Fees		Decatur Healthcare Estates	100.00%	2,347	2,347	3
4	V	30	Depreciation Expense		Decatur Healthcare Estates	100.00%	201,536	201,536	4
5	V	21	Filing Fees		Decatur Healthcare Estates	100.00%	250	250	5
6	V	32	Interest Expense		Decatur Healthcare Estates	100.00%	282,312	282,312	6
7	V	19	Professional Fees		Decatur Healthcare Estates	100.00%	5,118	5,118	7
8	V	33	Real Estate Taxes		Decatur Healthcare Estates	100.00%	80,000	80,000	8
9	V	33	Real Estate Taxes - Prior	2,028	Decatur Healthcare Estates	100.00%		(2,028)	9
10	V	32	Interest Income	184	Decatur Healthcare Estates	100.00%		(184)	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 452,212			\$ 571,563	\$ * 119,351	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%	\$ 7,266	\$ (10,374)	15
16	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	577	577	16
17	V	10	NURSING	35,280	S.I.R. MANAGEMENT, INC.	100.00%	10,638	(24,642)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	1,828	1,828	18
19	V	19	PROFESSIONAL FEES	118,908	S.I.R. MANAGEMENT, INC.	100.00%	8,706	(110,202)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	795	795	20
21	V	21	CLERICAL & GENERAL	35,280	S.I.R. MANAGEMENT, INC.	100.00%	35,794	514	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	475	475	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	6,543	6,543	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	988	988	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	3,139	3,139	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(5,979)	(5,979)	26
27	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	4,762	4,762	27
28	V								28
29	V	17	ADMINISTRATIVE	294,373	S.I.R. MANAGEMENT, INC.	100.00%	18,211	(276,162)	29
30	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	1,308		30
31	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	67,253	67,253	31
32	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	14,029	14,029	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 501,481			\$ 176,333	\$ * (326,456)	39

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%	\$ 4,994	\$ (12,646)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	868	868	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	5,194	5,194	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	899	899	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	53,078	53,078	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	10,325	10,325	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	11,985	11,985	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	17,640	S.I.R. MANAGEMENT, INC.	100.00%	6,878	(10,762)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,162	1,162	25
26	V								26
27	V	6	MAINTENANCE SALARIES	4,462	S.I.R. MANAGEMENT, INC.	100.00%	4,181	(281)	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	838	838	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	1,770	1,770	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	724	724	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	39	39	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	49	49	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	83	83	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	5,651	5,651	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	4,873	4,873	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	4,446	4,446	37
38	V	19	PROFESSIONAL FEES (RE TAX)		S.I.R. MANAGEMENT, INC.	100.00%	642	642	38
39	Total			\$ 39,742			\$ 118,679	\$ * 78,937	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	1	Dietary	\$	Xcel Supply, LLC	100.00%	\$	\$	15
16	V	3	Housekeeping	6,386	Xcel Supply, LLC	100.00%	5,999	(387)	16
17	V	4	Laundry	5,791	Xcel Supply, LLC	100.00%	5,440	(351)	17
18	V	6	Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10	Nursing	24,401	Xcel Supply, LLC	100.00%	22,921	(1,479)	19
20	V	11	Activities		Xcel Supply, LLC	100.00%			20
21	V	21	Office And Clerical		Xcel Supply, LLC	100.00%			21
22	V	22	Employee Benefits		Xcel Supply, LLC	100.00%			22
23	V	30	Fixed Assets-Depreciation	4,723	Xcel Supply, LLC	100.00%	4,437	(286)	23
24	V	39	Ancillary		Xcel Supply, LLC	100.00%			24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 41,300			\$ 38,797	\$ * (2,504)	39

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	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 57,774	\$ 57,774	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	57,774	CCS Employee Benefits Group	100.00%		(57,774)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 57,774			\$ 57,774	\$ *	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	Total			\$			\$	\$ *	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	Total			\$			\$	\$ *	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	Total			\$			\$	\$ *	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	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

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

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

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	ALIED ASSOCIATES, LLC	26.398%	ALBANY CARE INC	EVANSTON	DECATUR HEALTHCARE ESTA	LINCOLNWOOD	BUILDING CO.	1
2	BARRISH GROUP LIMITED	8.799%	BRYN MAWR CARE INC.	CHICAGO	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	2
3	BRYAN BARRISH TRUST	8.799%	COLUMBUS PARK NURSING & REHABILITATION CENTER, INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	FAY CHIN	1.342%	ELMWOOD CARE, INC.	ELMWOOD PARK	EXTENDED CARE-OWNER'S CO	LINCOLNWOOD	MANAGEMENT CO.	4
5	JEFF ORAVEC	1.342%	FAIRVIEW NURSING PLAZA, INC.	ROCKFORD	XCEL MEDICAL SUPPLY, LLC	EVANSTON	SUPPLIES	5
6	LOUISE BERGTHOLD	3.356%	GREENWOOD CARE, INC.	EVANSTON	CCS VEBA	EVANSTON	HEALTH INSURANCE	6
7	LYNN ETHELL	1.342%	MAPLEWOOD CARE, INC.	ELGIN				7
8	NENITA GUZMAN	1.342%	NEIGHBORS REHABILITATION CENTER,LLC	BYRON				8
9	PATRICIA MCDIARMID	1.342%	REGENCY REHABILITATION CENTER,LLC	NILES				9
10	RALPH GESUALDO	8.799%	ROCK ISLAND NURSING & REHAB CENTER,LLC	ROCK ISLAND				10
11	RALPH GESUALDO CHILDREN'S TRUST	8.799%	WILSON CARE, INC.	CHICAGO				11
12	RONALD NUNZIATO JR.	2.685%	APPLEWOOD REHABILITATION CENTER	MATTESON				12
13	THOMAS WINTER	6.711%						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

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	Michael Giannini	Relative	Administrative	N/A	See Attached	1.91	4.78%	Alloc. Salary	\$ 9,123	17-7	1
2	Bryan Barrish	Shareholder	Administrative	8.79	See Attached	2.19	4.87%	Alloc. Salary	10,926	17-7	2
3	Kirtsen Barrish	Relative	Clerical	N/A	See Attached	2.19	5.48%	Alloc. Salary	2,460	21-7	3
4	Sarah Barrish	Relative	Administrative	N/A	See Attached	2.73	5.46%	Alloc. Salary	6,541	17-7	4
5	Nenita Guzman	Shareholder	Dietary	3.36	See Attached	2.73	5.46%	Alloc. Salary	4,994	1-7	5
6	Louise Bergthold	Shareholder	Administrative	3.40	See Attached	0.66	1.10%	Alloc. Salary	2,295	17-7	6
7	Tom Winter	Shareholder	Administrative	6.71	See Attached	3.28	5.47%	Alloc. Salary	10,926	17-7	7
8	Patricia Mcdiarmid	Shareholder	Administrative	1.34	See Attached	2.73	5.46%	Alloc. Salary	7,037	17-7	8
9	Jeff Oravec	Shareholder	Administrative	1.34	See Attached	2.19	5.48%	Alloc. Salary	7,285	17-7	9
10	Fay Chin	Shareholder	Nursing	1.34	See Attached	2.19	5.48%	Alloc. Salary	5,194	10-7	10
11	Andrew Chin	Relative	Clerical	N/A	See Attached	2.19	5.48%	Alloc. Salary	3,930	21-7	11
12	See second Page 7 for the detail of the additional owner and related compensation										12
13								TOTAL	\$ 70,711		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

Ending: 12/31/11

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	6	REPAIRS AND MAINT.	PATIENT DAYS	837,569	13	\$ 133,007	\$ 59,965	45,756	\$ 7,266	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	837,569	13	10,563		45,756	577	2
3	10	NURSING	PATIENT DAYS	837,569	13	194,733	194,733	45,756	10,638	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	837,569	13	33,459		45,756	1,828	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	837,569	13	159,360	132,109	45,756	8,706	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	837,569	13	14,549		45,756	795	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	837,569	13	655,215	586,698	45,756	35,794	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	837,569	13	8,688		45,756	475	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	837,569	13	119,765		45,756	6,543	9
10	26	INSURANCE	PATIENT DAYS	837,569	13	18,080		45,756	988	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	837,569	13	57,453		45,756	3,139	11
12	32	INTEREST	PATIENT DAYS	837,569	13	(109,444)		45,756	(5,979)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	837,569	13	87,163		45,756	4,762	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	837,569	13	333,346	333,346	45,756	18,211	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	837,569	13	23,941		45,756	1,308	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	837,569	13	1,231,079	1,128,775	45,756	67,253	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	837,569	13	256,807		45,756	14,029	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,227,764	\$ 2,435,627		\$ 176,333	25

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	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	837,569	13	\$ 91,408	\$ 91,408	45,756	\$ 4,994	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	837,569	13	15,892		45,756	868	2
3	10	NURSING SALARIES	PATIENT DAYS	837,569	13	95,082	95,082	45,756	5,194	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	837,569	13	16,460		45,756	899	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	837,569	13	971,606	971,606	45,756	53,078	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	837,569	13	189,000		45,756	10,325	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	837,569	13	219,385		45,756	11,985	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	315,820	13	123,146	123,146	17,640	6,878	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	315,820	13	20,802		17,640	1,162	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	367,402	13	344,256	344,256	4,462	4,181	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	367,402	13	69,007		4,462	838	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,880	13	32,378		704	1,770	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,880	13	13,246		704	724	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,880	13	705		704	39	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,880	13	899		704	49	19
20	26	INSURANCE	ALLOCATED SQ FT	12,880	13	1,527		704	83	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,880	13	103,394		704	5,651	21
22	32	INTEREST	ALLOCATED SQ FT	12,880	13	89,152		704	4,873	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,880	13	81,334		704	4,446	23
24	19	PROFESSIONAL FEES (RE TAX	ALLOCATED SQ FT	12,880	13	11,747		704	642	24
25	TOTALS					\$ 2,490,426	\$ 1,625,498		\$ 118,679	25

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Xcel Supply, LLC
Street Address 2201 Main Street
City / State / Zip Code Evanston, IL 60202
Phone Number (847)328-7600
Fax Number (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation			\$	\$			1
2	3	Housekeeping	Direct Allocation						5,999	2
3	4	Laundry	Direct Allocation						5,440	3
4	6	Repairs & Maintenance	Direct Allocation							4
5	10	Nursing	Direct Allocation						22,921	5
6	11	Activities	Direct Allocation							6
7	21	Office And Clerical	Direct Allocation							7
8	22	Employee Benefits	Direct Allocation							8
9	30	Fixed Assets-Depreciation	Direct Allocation						4,437	9
10	39	Ancillary	Direct Allocation							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					\$	\$		38,797	25

Ending: 12/31/11

(847)905-4040

SEE ACCOUNTANTS' COMPILATION REPORT

Ending: 12/31/11

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

()

()

	1	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

Ending: 12/31/11

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Decatur Manor Healthcare # 0049262 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

()

()

	1	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

Ending: 12/31/11

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		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Centure Bank		X	Mortgage			\$	3,911,033			\$	282,312	1
2													2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	Lake Forest Bank		X	Line of Credit		04/2008		775,000		0.0500		14,654	6
7	GMAC		X	Note Payable				12,369				1,129	7
8	See Supplemental Schedule							12,558				(563)	8
9	TOTAL Facility Related						\$	4,710,960			\$	297,532	9
	B. Non-Facility Related*												
10	Interest Income		X									(32,316)	10
11	Interest Income - Bldg Co.		X									(184)	11
12													12
13	See Supplemental Schedule												13
14	TOTAL Non-Facility Related						\$				\$	(32,501)	14
15	TOTALS (line 9+line14)						\$	4,710,960			\$	265,031	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.)

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

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
6													6
7	TOTAL Long-Term												7
	Working Capital												
8	Hyundai Finance		X	Note Payable			\$		\$ 12,558			\$ 543	8
9	SIR Management Alloc.		X									(1,106)	9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital								12,558			(563)	14
	B. Non-Facility Related*												
15							\$		\$			\$	15
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related												20

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

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.		\$	78,000	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.)		\$	80,418	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	2,418	3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	80,000	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	7,350	5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	89,768	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	67,868	8	
		2007	71,865	9	
		2008	73,507	10	
		2009	74,716	11	
		2010	75,972	12	
2011 Accruals = 75972 x 1.04 = 80,000 (Rounded)					
SIR Management Allocation = \$4,446					

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	\$		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

2010 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 2010 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 2010.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. <u>07-07-34-351-013</u>	<u>Long Term Care Property</u>	\$ <u>75,972.12</u>	\$ <u>75,972.12</u>
2. <u>See Attached</u>	<u>Home Office Allocation</u>	\$ <u>76,900.85</u>	\$ <u>4,203.28</u>
3. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u>152,872.97</u>	\$ <u>80,175.40</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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.**

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Decatur Manor Healthcare</u>	COUNTY	<u>Macon</u>
---------------	---------------------------------	--------	--------------

FACILITY IDPH LICENSE NUMBER 0049262

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility/Yard</u>	<u>130,680</u>	<u>2008</u>	<u>\$ 100,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	130,680		\$ 100,000	3

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			1976	\$ 2,902,875	\$ 95,605	35	\$ 82,939	\$ (12,666)	\$ 320,148
5										
6										
7										
8										
	Improvement Type**									
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
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

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	Related Building Company (Pages 12F & 12G)		755,460	43,387		37,773	(5,614)	118,537	67
68	Related Party Allocations (Pages 12H & 12I)		82,316	2,572		3,663	1,091	35,351	68
69	Financial Statement Depreciation			27,017			(27,017)		69
70	TOTAL (lines 4 thru 69)		\$ 3,740,651	\$ 168,581		\$ 124,375	\$ (44,206)	\$ 474,036	70

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:

01/01/11

Ending:

12/31/11

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,740,651	\$ 168,581		\$ 124,375	\$ (44,206)	\$ 474,036	1
2	Water Heater	2008	5,369		20	537	537	2,080	2
3	Storage Shed	2008	3,425		20	343	343	1,184	3
4	Water Heater	2008	2,683		20	268	268	883	4
5	Closet Doors	2009	9,582		20	479	479	1,078	5
6	Wall Unit Fan	2009	3,708		20	185	185	448	6
7	Lighting	2009	3,859		20	193	193	531	7
8	Storage Shed	2009	3,600		20	180	180	450	8
9	Concrete Work	2009	3,000		20	150	150	350	9
10	6 Windows	2009	3,171		20	159	159	436	10
11	Bypass Doors	2010	3,100		20	620	620	1,240	11
12	Drop Ceiling	2010	9,585		20	959	959	1,358	12
13	Garage Doors	2010	2,500		20	500	500	542	13
14	Replace Window	2010	3,087		20	154	154	309	14
15	Door Replacement	2010	4,422		20	221	221	424	15
16	Roof Repair	2010	3,475		20	174	174	217	16
17	Security Camera System	2011	9,845		20	123	123	123	17
18	Power Generator	2011	54,850		20	457	457	457	18
19	Security Camera System	2011	9,845		20	123	123	123	19
20	Power Generator	2011	54,850		20	457	457	457	20
21	Hvac- Air Unit	2011	5,545		20	29	29	29	21
22	Tile Floors	2011	33,217		20	185	185	185	22
23	Replace Window	2011	2,919		20	146	146	146	23
24	Replace Temp Valves	2011	2,825		20	141	141	141	24
25	Install Pipe Line	2011	4,953		20	248	248	248	25
26	Pull Station Covers	2011	2,994		20	150	150	150	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,987,060	\$ 168,581		\$ 131,555	\$ (37,026)	\$ 487,625	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 Totals from Page 12B, Carried Forward		\$ 3,987,060	\$ 168,581		\$ 131,555	\$ (37,026)	\$ 487,625	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)		\$ 3,987,060	\$ 168,581		\$ 131,555	\$ (37,026)	\$ 487,625	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 12C, Carried Forward		\$ 3,987,060	\$ 168,581		\$ 131,555	\$ (37,026)	\$ 487,625	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		\$ 3,987,060	\$ 168,581		\$ 131,555	\$ (37,026)	\$ 487,625	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	Totals from Page 12D, Carried Forward		\$3,987,060	\$168,581		\$131,555	\$ (37,026)	\$487,625	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$3,987,060	\$168,581		\$131,555	\$ (37,026)	\$487,625	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:

01/01/11

Ending:

12/31/11

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Roof	2008	83,141	5,543	20	4,157	(1,386)	14,319	9
10	Hand Rails	2008	41,519	4,152	20	2,076	(2,076)	6,920	10
11	Demolition, Framing,Plumbing, Heating...	2008	71,200	3,560	20	3,560		12,460	11
12	Demolition, Electical,Plumbing, Painting,Flooring....	2008	455,946	22,797	20	22,797	0	72,191	12
13	Painting Doors	2008	7,840	784	20	392	(392)	1,241	13
14	Draperies	2008	35,206	3,521	20	1,760	(1,761)	5,345	14
15	Trane A/C Unit	2010	12,989	649	20	649	0	1,298	15
16	Fire Alarm	2010	7,539	377	20	377	(0)	754	16
17	Rooftop Heat Exchanger	2010	9,900	495	20	495		990	17
18	Satellite TV Install	2010	18,180	909	20	909		1,818	18
19	Paving Parking Lot	2010	12,000	600	20	600		1,200	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.

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		\$	\$		\$	\$	\$	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)		\$ 755,460	\$ 43,387		\$ 37,773	\$ (5,614)	\$ 118,537	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:

01/01/11

Ending:

12/31/11

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	SIR Properties - SIR Management	1993	24,742	785	35	707	(78)	12,371	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	SIR Management - Allocation	1993	6,273	175	20	311	136	5,909	9
10	SIR Management - Allocation	1994	20		20			20	10
11	SIR Management - Allocation	1995	143		20	7	7	118	11
12	SIR Management - Allocation	1997	9,639	216	20	473	257	7,128	12
13	SIR Management - Allocation	1999	758		20	38	38	464	13
14	SIR Management - Allocation	1999			20				14
15	SIR Management - Allocation	2000	895		20	45	45	516	15
16	SIR Management - Allocation	2007	2,875	265	20	144	(121)	603	16
17	SIR Management - Allocation	2008	7,923	757	20	499	(258)	1,920	17
18	SIR Management - Allocation	2009	19,688	180	20	984	804	2,210	18
19	SIR Management - Allocation	2011	487	20	20	10	(10)	10	19
20									20
21	SIR Properties - SIR Management Allocations	2010	1,493		20	75	75	100	21
22	SIR Properties - SIR Management Allocations	2009	1,486	130	20	74	(56)	208	22
23	SIR Properties - SIR Management Allocations	2007	433	36	20	22	(14)	108	23
24	SIR Properties - SIR Management Allocations	2002	98		20	5	5	47	24
25	SIR Properties - SIR Management Allocations	1999	3,135		20	157	157	1,959	25
26	SIR Properties - SIR Management Allocations	1998	1,498		20	75	75	1,011	26
27	SIR Properties - SIR Management Allocations	1997	93		20	5	5	72	27
28	SIR Properties - SIR Management Allocations	1994	236	6	20	12	6	206	28
29	SIR Properties - SIR Management Allocations	1993	401	2	20	20	18	371	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.

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	Related Party Information Continued								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)		\$82,316	\$2,572		\$3,663	\$1,091	\$35,351	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	\$1,072,656	\$65,359	\$107,255	\$41,896	10	\$412,049	71
72	Current Year Purchases	4,970	(280)	(4)	276	10	282	72
73	Fully Depreciated Assets	21,709		12	12	10	21,709	73
74								74
75	TOTALS	\$1,099,335	\$65,079	\$107,263	\$42,184		\$434,039	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	Facility	GMAC VAN	2008	\$30,038	\$	\$6,008	\$6,008	5	\$20,025	76
77		Allocated from SIR Management	2011	1,921	236	272	36	5	381	77
78										78
79										79
80	TOTALS			\$31,959	\$236	\$6,280	\$6,044		\$20,406	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$5,218,354	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$233,896	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$245,097	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$11,201	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$942,070	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

**

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

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

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: \$ 11,407
- 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

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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training CNAs from other facilities.

		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

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

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	N/A	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental									13
14	TOTAL			\$		\$	\$		\$	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 55,520	\$ 91,762	1
2	Cash-Patient Deposits	13,190	13,190	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	851,355	851,355	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,387	17,387	6
7	Other Prepaid Expenses	1,826	1,826	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 939,278	\$ 975,520	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,000	13
14	Buildings, at Historical Cost		2,902,875	14
15	Leasehold Improvements, at Historical Cost	120,800	120,800	15
16	Equipment, at Historical Cost	178,829	1,237,868	16
17	Accumulated Depreciation (book methods)	(77,403)	(150,147)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		64,528	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(21,126)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	1,032,446	2,482,446	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,254,672	\$ 6,737,244	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,193,950	\$ 7,712,764	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 212,889	\$ 212,889	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,190	13,190	28
29	Short-Term Notes Payable	775,000	775,000	29
30	Accrued Salaries Payable	106,560	106,560	30
31	Accrued Taxes Payable (excluding real estate taxes)	23,028	23,028	31
32	Accrued Real Estate Taxes(Sch.IX-B)		80,000	32
33	Accrued Interest Payable		1,350	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	18,799	18,799	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,149,466	\$ 1,230,816	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	24,927	24,927	39
40	Mortgage Payable		3,911,033	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule		1,030,685	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 24,927	\$ 4,966,645	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,174,393	\$ 6,197,461	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,019,557	\$ 1,515,303	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,193,950	\$ 7,712,764	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,088,795	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,088,795	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	310,712	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	(379,950)	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)	\$ (69,238)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,019,557	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			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,476,008	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,476,008	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	27,853	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 27,853	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	32,316	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 32,316	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	3,343	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,343	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,539,520	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,006,292	31
32	Health Care	1,466,334	32
33	General Administration	1,175,711	33
	B. Capital Expense		
34	Ownership	499,988	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	80,483	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,228,808	40
41	Income before Income Taxes (line 30 minus line 40)**	310,712	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 310,712	43

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

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

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

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

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	2,753	2,938	\$ 96,121	\$ 32.72	1
2	Assistant Director of Nursing	2,573	2,766	77,653	28.07	2
3	Registered Nurses	1,686	1,705	39,018	22.88	3
4	Licensed Practical Nurses	10,952	11,299	229,275	20.29	4
5	CNAs & Orderlies	52,020	54,348	495,978	9.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,916	2,046	33,389	16.32	9
10	Activity Assistants	5,304	5,518	47,664	8.64	10
11	Social Service Workers	11,563	12,269	155,302	12.66	11
12	Dietician					12
13	Food Service Supervisor	1,949	2,086	38,015	18.22	13
14	Head Cook	2,161	2,313	22,048	9.53	14
15	Cook Helpers/Assistants	15,465	16,152	136,533	8.45	15
16	Dishwashers					16
17	Maintenance Workers	3,244	3,344	41,826	12.51	17
18	Housekeepers	13,113	13,714	136,225	9.93	18
19	Laundry	3,584	3,804	31,778	8.35	19
20	Administrator	1,909	2,086	91,881	44.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,210	8,686	105,399	12.13	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	4,334	4,688	84,161	17.95	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	142,736	149,762	\$ 1,862,266 *	\$ 12.43	34

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	\$ 31,562	01-03	35
36	Medical Director				36
37	Medical Records Consultant	Monthly	850	10-03	37
38	Nurse Consultant	Monthly	35,280	10-03	38
39	Pharmacist Consultant	Monthly	8,531	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	976	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psych Medical Director	Monthly	48,000	10-03	47
48	Specialized Rehab Consult.	Monthly	17,640	10A-03	48
49	TOTAL (lines 35 - 48)		\$ 142,839		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

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberDecatur Manor Healthcare# 0049262Report Period Beginning:01/01/11Ending:12/31/11Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Charles Jordan	Administrator	0.00%	\$ 91,881
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 91,881

B. Administrative - Other

Description	Amount
SIR Management - Management Fees	\$ 223,813
SIR Management - Dir of Admin Services	35,280
SIR Management Ancillary Admin. Charges	35,280
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR&R	Accounting	\$ 12,363
Personnel Planners	Unemployment Tax Consult.	1,570
LTC Solutions Inc	MDS Software	1,600
Health Data	Computer Software	151
See Attached	Legal	9,070
SIR Management	Accounting	36,000
SIR Management	Dir. Of Regulatory Services	17,640
SIR Management	Bookkeeping	65,268
Honkamp Krueger	Consulting	1,478
Skidelsky & Associates	Real Estate Tax Protest	6,708
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 151,848

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 34,887
Unemployment Compensation Insurance	92,872
FICA Taxes	140,064
Employee Health Insurance	30,791
Employee Meals	6,169
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	6,177
TOTAL (agree to Schedule V, line 22, col.8)	

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

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	9,434
Health Care Worker Background Check (Indicate # of checks performed 74)	6,683
Patient Background Checks	
Dues & Subscriptions	475
Licenses & Permits	723
SIR Management Allocation	795
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	993
SIR Management Allocation	475
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 1,468

* 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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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? No
If YES, give association name and amount. Alliance for Living \$11,466
- (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? _____
- (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. \$ _____ 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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 80,483
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. \$ 6,169 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln14
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.