

		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>0013334</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Sacred Heart Home Inc.</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>1550 S. Albany</u> <u>Chicago</u> <u>60623</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(773) 277-6868</u> Fax # <u>(773) 277-5014</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>Jeffrey K. Singer, 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>Jeffrey K. Singer, 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>01/01/71</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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	☒ "Sub-S" Corp.																								
	☐ 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 Sacred Heart Home Inc.

0013334 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	172	Intermediate (ICF)	172	62,780	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	172	TOTALS	172	62,780	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	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	48,082	559		48,641	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,082	559		48,641	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.48%

D. How many bed-hold days during this year were paid by the Department? N/A (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location? Date started 7/1/1971

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAUAL X MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES X 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 Sacred Heart Home Inc. # 0013334 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	279,019	34,218	54,950	368,187		368,187		368,187			1
2	Food Purchase		385,999		385,999	(45,074)	340,925	(44)	340,881			2
3	Housekeeping	300,175	90,555		390,730		390,730		390,730			3
4	Laundry	41,989	18,129		60,118		60,118		60,118			4
5	Heat and Other Utilities			130,591	130,591		130,591	(1,065)	129,526			5
6	Maintenance	357,078		130,335	487,413		487,413	18,174	505,587			6
7	Other (specify):*											7
8	TOTAL General Services	978,261	528,901	315,876	1,823,038	(45,074)	1,777,964	17,065	1,795,029			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,149,699	60,415	344,519	1,554,633		1,554,633	(2,720)	1,551,913			10
10a	Therapy											10a
11	Activities	259,289	21,597	1,764	282,650		282,650		282,650			11
12	Social Services	187,276	1,090	116,113	304,479		304,479	(1,052)	303,427			12
13	CNA Training											13
14	Program Transportation			8,646	8,646		8,646		8,646			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,596,264	83,102	477,042	2,156,408		2,156,408	(3,772)	2,152,636			16
	C. General Administration											
17	Administrative			673,201	673,201		673,201	(417,389)	255,812			17
18	Directors Fees											18
19	Professional Services			86,008	86,008		86,008	(41,693)	44,315			19
20	Dues, Fees, Subscriptions & Promotions			27,467	27,467		27,467	(839)	26,628			20
21	Clerical & General Office Expenses	28,100	35,908	97,199	161,207		161,207	84,384	245,591			21
22	Employee Benefits & Payroll Taxes			358,435	358,435	45,074	403,509		403,509			22
23	Inservice Training & Education											23
24	Travel and Seminar			403	403		403		403			24
25	Other Admin. Staff Transportation							4,233	4,233			25
26	Insurance-Prop.Liab.Malpractice			135,016	135,016		135,016	8,223	143,239			26
27	Other (specify):*							66,628	66,628			27
28	TOTAL General Administration	28,100	35,908	1,377,729	1,441,737	45,074	1,486,811	(296,453)	1,190,357			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,602,625	647,911	2,170,647	5,421,183		5,421,183	(283,160)	5,138,023			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			121,865	121,865		121,865	57,897	179,762			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,062	6,062		6,062	5,285	11,347			32
33	Real Estate Taxes							12,236	12,236			33
34	Rent-Facility & Grounds			188,400	188,400		188,400	(188,400)				34
35	Rent-Equipment & Vehicles			6,531	6,531		6,531		6,531			35
36	Other (specify):*											36
37	TOTAL Ownership			322,858	322,858		322,858	(112,982)	209,876			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			1,862	1,862		1,862		1,862			40
41	Coffee and Gift Shops		43,455		43,455		43,455	(29,312)	14,143			41
42	Provider Participation Fee			94,170	94,170		94,170		94,170			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		43,455	96,032	139,487		139,487	(29,312)	110,175			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,602,625	691,366	2,589,537	5,883,528		5,883,528	(425,454)	5,458,074			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	56,778	30		9
10	Interest and Other Investment Income				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	(35,551)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(11,343)	21		24
25	Fund Raising, Advertising and Promotional	(999)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(289)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(180,194)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (171,642)		\$	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)	(253,812)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (253,812)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (425,454)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Sacred Heart Home Inc.

	ID#	0013334
Report Period Beginning:		01/01/11
Ending:		12/31/11

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Additional R&M	\$ 17,696	6	1
2	Vending Income	(29,312)	41	2
3	Bank Charges	(10,020)	21	3
4	PPA - R&M	(101)	06	4
5	PPA - Social Service	(1,052)	12	5
6	Building Co. - Management Fees	(90,000)	17	6
7	Building Co. - Licenses & Fees	(258)	20	7
8	Building Co. - Corporate Income Taxes	(1,125)	21	8
9	Building Co. - Professional Fees	(2,294)	19	9
10	Non- Allowable Professional Fees	(4,240)	19	10
11	Annual Report	(100)	20	11
12	Annual Fee	(155)	20	12
13	Non-Allowable Legal	(41,189)	19	13
14	IOP Rented Space - Utilities	(3,060)	05	14
15	IOP Rented Space - Maintenance	(3,054)	06	15
16	IOP Rented Space - Insurance	(3,163)	26	16
17	IOP Rented Space - Depreciation	(5,258)	30	17
18	IOP Rented Space - Real Estate Tax	(170)	33	18
19	IOP Rented Space - Interest	(142)	32	19
20	PPA - Outside Labor- LPN	(2,720)	10	20
21	PPA - Fines	(477)	21	21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(180,194)		49

Sacred Heart Home Inc.

ID# 0013334

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
67				18
68				19
69				20
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71				22
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74				25
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76				27
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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				49

Summary A

12/31/11

[illegible]

Summary B

12/31/11

[illegible]

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		
				Long Term Care		Building Co.

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	\$ 188,400	Long Term Care	100.00%	\$	(188,400)	1
2	V	33	Real Estate Taxes		Long Term Care	100.00%	9,029	9,029	2
3	V	17	Management Fee		Long Term Care	100.00%	90,000	90,000	3
4	V	20	Licences & Fees		Long Term Care	100.00%	258	258	4
5	V	21	Corporate Income Taxes		Long Term Care	100.00%	1,125	1,125	5
6	V	19	Professional Fees		Long Term Care	100.00%	2,294	2,294	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 188,400			\$ 102,706	\$ * (85,694)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ 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	5	UTILITIES	\$	MADO MGMT. LP	100.00%	\$ 1,995	\$ 1,995	15
16	V	6	REPAIRS AND MAINT.		MADO MGMT. LP	100.00%	3,633	3,633	16
17	V	17	ADMINISTRATIVE		MADO MGMT. LP	100.00%	6,664	6,664	17
18	V	19	PROFESSIONAL FEES		MADO MGMT. LP	100.00%	3,736	3,736	18
19	V	20	DUES AND SUBSCRIPTIONS		MADO MGMT. LP	100.00%	415	415	19
20	V	21	CLERICAL AND GENERAL		MADO MGMT. LP	100.00%	142,064	142,064	20
21	V	25	AUTO EXPENSE		MADO MGMT. LP	100.00%	4,233	4,233	21
22	V	26	PROPERTY INSURANCE		MADO MGMT. LP	100.00%	11,386	11,386	22
23	V	27	GEN. ADMIN. - EMP. BEN.		MADO MGMT. LP	100.00%	33,675	33,675	23
24	V	30	DEPRECIATION		MADO MGMT. LP	100.00%	6,377	6,377	24
25	V	32	INTEREST		MADO MGMT. LP	100.00%	5,427	5,427	25
26	V	33	REAL ESTATE TAXES		MADO MGMT. LP	100.00%	3,377	3,377	26
27	V								27
28	V	17	MANAGEMENT FEES	618,000	MADO MGMT. LP	100.00%		(618,000)	28
29	V								29
30	V	17	SALARY-P. O'BRIEN		MADO MGMT. LP	100.00%	38,947	38,947	30
31	V	27	EMP. BEN.-P. O'BRIEN		MADO MGMT. LP	100.00%	6,501	6,501	31
32	V								32
33	V					100.00%			33
34	V	17	ADMINISTRATIVE SALARY		MADO MGMT. LP	100.00%	155,000	155,000	34
35	V	27	GEN. ADMIN. - EMP. BEN.		MADO MGMT. LP	100.00%	26,452	26,452	35
36	V	33	REAL ESTATE TAXES		MADO MGMT. LP	100.00%			36
37	V								37
38	V								38
39	Total			\$ 618,000			\$ 449,882	\$ * (168,118)	39

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	\$ 242,081	WINDY CITY NURSING	100.00%	\$ 242,081	\$	15
16	V	01	DIETARY	54,950	WINDY CITY NURSING	100.00%	54,950		16
17	V	21	CLERICAL	77,080	WINDY CITY NURSING	100.00%	77,080		17
18	V	06	MAINTENANCE	30,926	WINDY CITY NURSING	100.00%	30,926		18
19	V	12	SOCIAL SERVICES	103,685	WINDY CITY NURSING	100.00%	103,685		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			\$ 508,722			\$ 508,722	\$ *	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 (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

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

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	DANIEL O'BRIEN	20.000%	MARGARET MANOR, INC.	CHICAGO	LONG TERM CARE		BUILDING CO.	1
2	MARY O'BRIEN	20.000%	NINE FORTY COLLOM CORPORATION □ D/B/A MARGARET MANOR	CHICAGO	WINDY CITY NURSING (CONT.)	CHICAGO	NURSING, DIETARY, AC	2
3	PETER O'BRIEN	60.000%	ST. AGNES MANOR INC.	CHICAGO	WINDY CITY NURSING	CHICAGO	OUTSIDE LABOR FOR:	3
4			FORTY SIX TWENTY ONE CORPORATION INCORPORATED □ D/B/A	CHICAGO	MADO MANAGEMENT	CHICAGO	BOOKEEPING / MANAGI	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

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

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	Peter O'Brien	Owner	Administrative	60.00%	See Attached	10	17%	Alloc. Salary	\$ 38,947	17-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts anticipated to be considered allowable										8
9	by the IL. Dept of HFS.										9
10											10
11											11
12											12
13								TOTAL	\$ 38,947		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Sacred Heart Home Inc. # 0013334 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

Facility Name & ID Number Sacred Heart Home Inc. # 0013334 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 MADO MGMT. LP
Street Address 1541 N. WELLS ST.
City / State / Zip Code CHICAGO, IL. 60610
Phone Number (312) 787-9400
Fax Number (312) 787-9434

	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	5	UTILITIES	PATIENT DAYS	224,804	5	\$ 9,221	\$	48,641	\$ 1,995	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	224,804	5	16,792		48,641	3,633	2
3	17	ADMINISTRATIVE	PATIENT DAYS	224,804	5	30,800	30,800	48,641	6,664	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	224,804	5	17,267		48,641	3,736	4
5	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	224,804	5	1,919		48,641	415	5
6	21	CLERICAL AND GENERAL	PATIENT DAYS	224,804	5	656,578	593,075	48,641	142,064	6
7	25	AUTO EXPENSE	PATIENT DAYS	224,804	5	19,564		48,641	4,233	7
8	26	PROPERTY INSURANCE	PATIENT DAYS	224,804	5	52,624		48,641	11,386	8
9	27	GEN. ADMIN. - EMP. BEN.	PATIENT DAYS	224,804	5	155,635		48,641	33,675	9
10	30	DEPRECIATION	PATIENT DAYS	224,804	5	29,474		48,641	6,377	10
11	32	INTEREST	PATIENT DAYS	224,804	5	25,083		48,641	5,427	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	224,804	5	15,609		48,641	3,377	12
13										13
14										14
15										15
16	17	SALARY-P. O'BRIEN	AVG. HOURS WORKED	46	5	180,000	180,000	10	38,947	16
17	27	EMP. BEN.-P. O'BRIEN	AVG. HOURS WORKED	46	5	30,045		10	6,501	17
18										18
19										19
20	17	ADMINISTRATIVE SALARY	DIRECT ALLOCATION		5	512,073	512,073		155,000	20
21	27	GEN. ADMIN. - EMP. BEN.	DIRECT ALLOCATION		5	89,705			26,452	21
22	33	REAL ESTATE TAXES	DIRECT ALLOCATION		1	4,375				22
23										23
24										24
25	TOTALS					\$ 1,846,764	\$ 1,315,948		\$ 449,882	25

Facility Name & ID Number Sacred Heart Home Inc. # 0013334 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 WINDY CITY NURSING
Street Address 1541 N. WELLS ST.
City / State / Zip Code CHICAGO, IL. 60610
Phone Number (312) 787-9400
Fax Number (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT ALLOCATION			\$	\$		242,081	1
2	1	DIETARY	DIRECT ALLOCATION						54,950	2
3	21	CLERICAL	DIRECT ALLOCATION						77,080	3
4	6	MAINTENANCE	DIRECT ALLOCATION						30,926	4
5	12	SOCIAL SERVICES	DIRECT ALLOCATION						103,685	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					\$	\$		508,722	25

Facility Name & ID Number Sacred Heart Home Inc. # 0013334 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

Facility Name & ID Number Sacred Heart Home Inc. # 0013334 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

Facility Name & ID Number Sacred Heart Home Inc. # 0013334 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

Facility Name & ID Number Sacred Heart Home Inc. # 0013334 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

Facility Name & ID Number Sacred Heart Home Inc. # 0013334 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

Facility Name & ID Number Sacred Heart Home Inc. # 0013334 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

Facility Name & ID Number Sacred Heart Home Inc. # 0013334 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

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	Bridgview Bank		X				\$	225,800			\$	5,920	1
2													2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	Allocated from MAD0 Management		X									5,427	6
7													7
8	See Supplemental Schedule												8
9	TOTAL Facility Related						\$	225,800			\$	11,347	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13	See Supplemental Schedule												13
14	TOTAL Non-Facility Related						\$				\$		14
15	TOTALS (line 9+line14)						\$	225,800			\$	11,347	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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							\$	\$			\$	8							
9												9							
10												10							
11												11							
12												12							
13												13							
14	TOTAL Working Capital											14							
	B. Non-Facility Related*																		
15							\$	\$			\$	15							
16												16							
17												17							
18												18							
19												19							
20	TOTAL Non-Facility Related											20							

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

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

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.		\$	26,218	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.)		\$	10,639	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(15,579)	3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	27,815	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.		\$		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	12,236	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	4,698	8	
		2007	4,648	9	
		2008	4,695	10	
		2009	6,959	11	
		2010	7,262	12	
Beginning Accrual Adjusted					
Allocated from MAD0 Management = \$3,377					

		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

FACILITY NAME	<u>Sacred Heart Home Inc.</u>	COUNTY	<u>Cook</u>
FACILITY IDPH LICENSE NUMBER	<u>0013334</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Steve Lavenda</u>		
TELEPHONE	<u>(847) 236-1111</u>	FAX #:	<u>(847) 236-1155</u>

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.

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>Sacred Heart Home Inc.</u>	COUNTY	<u>Cook</u>
---------------	-------------------------------	--------	-------------

FACILITY IDPH LICENSE NUMBER 0013334

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: 79,940

B. General Construction Type: ExteriorFrameNumber of Stories 3

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	Facility			\$ 22,077	1
2					2
3	TOTALS			\$ 22,077	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	172			1971	\$ 140,000	\$		\$		\$ 140,000	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Various			1973	9,000		20			9,000	9	
10	Various			1975	16,880		20			16,880	10	
11	Various			1976	4,234		20			4,234	11	
12	Various			1977	43,234		20			43,234	12	
13	Various			1978	50,867		20			50,867	13	
14	Various			1979	40,393		20			40,393	14	
15	Various			1980	4,392		20			4,392	15	
16	Various			1981	15,817		20			15,817	16	
17	Various			1982	15,180		20			15,180	17	
18	Various			1984	7,505		20			7,505	18	
19	Various			1985	60,377		20			60,377	19	
20	Various			1986	41,792		20			41,792	20	
21	Various			1987	17,344		20			17,344	21	
22	Various			1988	13,840		20			13,824	22	
23	Various			1989	10,568		20			10,568	23	
24	Various			1990	48,324		20			48,324	24	
25	Various			1991	26,113		20	55	55	25,972	25	
26	Various			1992	105,671		20			105,671	26	
27	Various			1993	14,487		20			14,487	27	
28	Various			1994	37,950		20	1,898	1,898	34,159	28	
29	Various			1995	38,705		20	1,935	1,935	30,963	29	
30	Various			1996	34,431		20	1,722	1,722	27,874	30	
31	Various			1997	62,792		20	3,140	3,140	45,390	31	
32	Various			1998	73,236		20	3,662	3,662	50,373	32	
33	Various			1999	51,272		20	2,564	2,564	31,974	33	
34	Various			2000	120,486		20	6,024	6,024	70,020	34	
35	Various			2001	159,720		20	7,986	7,986	83,505	35	
36	Various			2002	148,315		20	13,762		140,149	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

Facility Name & ID Number Sacred Heart Home Inc.

0013334

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	
37	Various	2003	\$ 140,910	\$	20	\$ 14,091	\$ 14,091	\$ 119,215	37
38	Various	2004	159,051		20	15,905	15,905	119,822	38
39	Various	2005	156,033		20	9,221	9,221	59,159	39
40	Various	2006	173,699		20	16,147	16,147	87,257	40
41	Various	2007	134,430		20	13,268	13,268	61,173	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)								67
68	Related Party Allocations (Pages 12H & 12I)		68,864	2,099		2,552	453	40,870	68
69	Financial Statement Depreciation			116,606			(116,606)		69
70	TOTAL (lines 4 thru 69)		\$ 2,245,912	\$ 118,705		\$ 113,930	\$ (18,537)	\$ 1,687,763	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sacred Heart Home Inc.

0013334

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	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 12A, Carried Forward		\$ 2,245,912	\$ 118,705		\$ 113,930	\$ (4,775)	\$ 1,687,763	1
2	Upgrade Water Lines - 2Nd Floor Bathrrom	2008	17,045		20	852	852	3,054	2
3	Upgrade Water Lines - 2Nd Floor Bathrooms.	2008	14,847		20	742	742	2,289	3
4	Upgrade Water Lines - 3Rd Floor Bathrooms	2008	3,720		20	186	186	574	4
5	Resident Room Doors	2008	2,520		20	126	126	493	5
6	Catch Basins & Sewer Line Upgrade	2008	10,609		20	530	530	1,901	6
7	Power Supply - Exit Signs	2008	2,785		20	139	139	487	7
8	Replace Lintels - North Wall	2008	7,860		20	393	393	1,310	8
9	Repairs In 2Nd Floor Bathrooms	2008	3,900		20	195	195	748	9
10	Roof Repair	2008	4,500		20	225	225	731	10
11	Tuckpointing Of Roof - South Side Of Bldg	2008	4,800		20	240	240	780	11
12	Pump Motor & Thermostatic Valve	2009	4,579		20	229	229	649	12
13	Removal & Repaving Of Courtyard	2009	7,000		20	350	350	904	13
14	New Layer Of Hot Roofing Rubber	2009	4,700		20	235	235	588	14
15	Doors For Resident Rooms	2009	3,352		20	168	168	405	15
16	Hot Water Heater & Installation Supplies	2009	4,564		20	228	228	551	16
17	Removal Of Fire Escape	2009	32,500		20	1,625	1,625	3,927	17
18	Brickwork For Doorways & Windows	2009	4,500		20	225	225	525	18
19	Closure Of 12 Fire Exit Doors	2009	5,056		20	253	253	590	19
20	Replaced Broken Pipe; Paved Hole - Courtyard	2009	2,943		20	147	147	319	20
21	Upgrade Boiler Room & Sewer	2009	2,548		20	127	127	276	21
22	Labor - Conversion Of Hobby Room To Activity Room	2009	5,355		20	268	268	558	22
23	Labor - Electrical Work - Nurses Station Renovation	2009	16,040		20	802	802	1,671	23
24	2Nd & 3Rd Flr Bathrooms- Tiles, Shelves, Flushometer	2009	22,471		20	1,124	1,124	3,090	24
25	Coverion Of Hobby Room To Activiy Room- Flooring, Walls, Pai	2009	4,543		20	227	227	511	25
26	2Nd Flr Nurses Station& Activity Rm- Tiles, Paint, Ceiling	2009	16,020		20	801	801	1,669	26
27	2Nd Flr Nurses Station & Bathroom- Fixtures, Paint, Doors	2009	5,690		20	284	284	664	27
28	Install & Paint Iron Fence & Gate	2009	3,900		20	195	195	423	28
29	Upgrade 2Nd Floor Nurses Station- Flooring, Wall Work	2009	7,633		20	382	382	827	29
30	Upgrade Courtyard Gate	2009	2,754		20	138	138	287	30
31	Installation Of Exterior Lighting - Courtyard	2009	9,875		20	494	494	1,276	31
32	2Nd Flr Nurses Station- Flooring, New Wall, Cabinets/Counter To	2009	14,621		20	731	731	1,523	32
33	2Nd & 3Rd Floor Security System - Cameras & Monitor	2010	4,872		20	244	244	447	33
34	TOTAL (lines 1 thru 33)		\$ 2,504,013	\$ 118,705		\$ 126,836	\$ 8,131	\$ 1,721,807	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sacred Heart Home Inc.

0013334

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	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 12B, Carried Forward		\$ 2,504,013	\$ 118,705		\$ 126,836	\$ 8,131	\$ 1,721,807	1
2	Water Heater For Laundry	2010	4,162		20	416	416	520	2
3	Fire Alarm System Work	2010	3,400		20	170	170	198	3
4	Furnished And Installed Terrazzo Flooring	2010	4,300		20	215	215	430	4
5	Smoke Detectors & Fire Panels	2010	26,847		20	1,342	1,342	2,573	5
6	Fire Rated Doors	2010	10,594		20	530	530	1,015	6
7	Conversion Of Activity Room To Rehab Office	2010	5,843		20	292	292	536	7
8	Window Screens	2010	4,239		20	212	212	389	8
9	Compressor For Fire Pump	2010	3,705		20	185	185	340	9
10	Furnished & Installed Pedestrian Door	2010	2,828		20	141	141	259	10
11	Furnished & Replaced Broken Section Of Boiler	2010	15,125		20	756	756	1,323	11
12	Electric Upgrade & Outlets For A/C	2010	28,750		20	1,438	1,438	2,396	12
13	New Central Heating & A/C Unit	2010	18,715		20	936	936	1,716	13
14	Doors & Supplies For 1St Floor Bathroom & Stairs	2010	3,611		20	181	181	286	14
15	1St Floor Bathrooms - Plumbing	2010	12,300		20	615	615	974	15
16	Electrical Work On 2Nd & 3Rd Floors	2010	2,875		20	144	144	216	16
17	Upgrade Fire Sprinkler System	2010	10,842		20	542	542	768	17
18	Floor Tiles - Iop Project	2010	7,981		20	399	399	532	18
19	Ceiling Tiles And Doors For Iop Office	2010	4,007		20	200	200	267	19
20	Electrical Work For Iop Office	2010	5,075		20	254	254	317	20
21	New Hvac For Iop Office	2010	6,220		20	311	311	389	21
22	Upgrade Electrical Panel	2010	4,587		20	229	229	287	22
23	Bathroom Renovation - Walls, Plumbing, Showers, Tubs, Lighting	2010	72,577		20	3,629	3,629	3,931	23
24	Iop Office Conversion - Demolition, Drywall, Electrical, Flooring,	2010	78,375		20	3,919	3,919	4,245	24
25	Iop Office Bathroom - Doors & Supplies	2010	3,492		20	175	175	233	25
26	Sprinkler Head Installations	2010	2,945		20	147	147	172	26
27	2Nd Floor Bathrooms - Frame, Drywall, Floor, Tile, Shower Pan,	2011	14,741		20	676	676	676	27
28	3Rd Floor Bathrooms - Frame, Drywall, Floor, Tile, Shower Pan,	2011	5,231		20	240	240	240	28
29	Janitor Closets - New Pipes, Walls, Tile, Sinks	2011	13,358		20	557	557	557	29
30	Reception & Conference Rm - Walls, Doors, Duct Work, Tile, Cab	2011	33,828		20	2,819	2,819	2,819	30
31	3Rd Floor Tiage Unit - Walls, Floor, Electrical Fixtures, Doors, Sii	2011	116,104		20	1,935	1,935	1,935	31
32	Fire Sprinklers - Elevator	2011	5,884		20	221	221	221	32
33	Fire Sprinklers - Reception & Lounge	2011	3,077		20	115	115	115	33
34	TOTAL (lines 1 thru 33)		\$ 3,039,632	\$ 118,705		\$ 150,775	\$ 32,070	\$ 1,752,680	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		\$ 3,039,632	\$ 118,705		\$ 150,775	\$ 32,070	\$ 1,752,680	1
2	Additional Fire Sprinklers For State Compliance	2011	6,722		20	224	224	224	2
3	Fire Sprinklers - Janitor Closets	2011	3,716		20	124	124	124	3
4	Fire Sprinklers - Canopy	2011	2,708		20	90	90	90	4
5	New Windows	2011	6,924		20	144	144	144	5
6	Fire Sprinklers - Triage	2011	6,266		20	26	26	26	6
7	Transitional Living Unit - Vents, Drains, Sewer Connect, Window	2011	89,875		20	4,119	4,119	4,119	7
8	Transitional Unit Construction Drawing & Permit	2011	13,959		20	116	116	116	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)		\$ 3,169,802	\$ 118,705		\$ 155,620	\$ 36,915	\$ 1,757,524	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sacred Heart Home Inc.

0013334

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 12D, Carried Forward		\$ 3,169,802	\$ 118,705		\$ 155,620	\$ 36,915	\$ 1,757,524	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)		\$ 3,169,802	\$ 118,705		\$ 155,620	\$ 36,915	\$ 1,757,524	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	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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									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	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)		\$	\$		\$	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sacred Heart Home Inc.

0013334

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	MADO Management Allocation	1988	44,848	1,638	35	1,281	(357)	20,502	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	MADO Management Allocation	1995	1,040		20	52	52	858	9
10	MADO Management Allocation	1993	17,083	455	20	854	399	15,737	10
11	MADO Management Allocation	2000	2,555		20	128	128	1,472	11
12	MADO Management Allocation	2001	1,107		20	55	55	594	12
13	MADO Management Allocation	2002	1,741		20	157	157	1,529	13
14	MADO Management Allocation	2004	490	6	20	25	19	178	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

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
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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)		\$68,864	\$2,099		\$2,552	\$453	\$40,870	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	\$273,032	\$145	\$17,164	\$17,019	10	\$202,651	71
72	Current Year Purchases	12,614		677	677	10	677	72
73	Fully Depreciated Assets	200,948		155	155	10	198,407	73
74								74
75	TOTALS	\$486,594	\$145	\$17,996	\$17,851		\$401,734	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		1997 JEEP GRAND CHER	1998	\$24,457	\$	\$	\$	5	\$24,456	76
77		Allocated from MADO Managem	2010	47,223	4,134	6,147	2,013	5	33,424	77
78										78
79										79
80	TOTALS			\$71,680	\$4,134	\$6,147	\$2,013		\$57,880	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)	\$3,750,152	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$122,984	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$179,762	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$56,778	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,217,137	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	BOILER REPAIR - 1997	\$2,297	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$2,297	\$	\$	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: \$ 6,531
- 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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	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
11	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 61,214	\$ 61,214	1
2	Cash-Patient Deposits	99	99	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,669,910	1,669,910	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,814	9,814	6
7	Other Prepaid Expenses	475	475	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	10,049	10,049	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,751,561	\$ 1,751,561	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		15,865	13
14	Buildings, at Historical Cost		140,000	14
15	Leasehold Improvements, at Historical Cost	2,664,237	2,664,237	15
16	Equipment, at Historical Cost	607,316	622,316	16
17	Accumulated Depreciation (book methods)	(1,863,664)	(2,018,664)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	532,297	2,920,452	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,940,186	\$ 4,344,206	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,691,747	\$ 6,095,767	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 942,624	\$ 942,623	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,381	8,381	28
29	Short-Term Notes Payable	225,800	225,800	29
30	Accrued Salaries Payable	105,108	105,108	30
31	Accrued Taxes Payable (excluding real estate taxes)	420	420	31
32	Accrued Real Estate Taxes(Sch.IX-B)		27,815	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes		979	35
	Other Current Liabilities(specify):			
36	See Attached Schedule			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,282,333	\$ 1,311,126	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,282,333	\$ 1,311,126	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,409,414	\$ 4,784,641	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,691,747	\$ 6,095,767	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,013,777	1
2	Restatements (describe):		2
3	Outside Labor-LPN	(8,313)	3
4	Rounding Error	1	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,005,465	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(596,051)	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	()	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)	\$ (596,051)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,409,414	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	\$ 5,143,994	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,143,994	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	29,312	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	114,171	16
17	Sale of Drugs		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)	\$ 143,483	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>		28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,287,477	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,823,038	31
32	Health Care	2,156,408	32
33	General Administration	1,441,737	33
	B. Capital Expense		
34	Ownership	322,858	34
	C. Ancillary Expense		
35	Special Cost Centers	45,317	35
36	Provider Participation Fee	94,170	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,883,528	40
41	Income before Income Taxes (line 30 minus line 40)**	(596,051)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (596,051)	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			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,443	1,571	42,194	26.86	3
4	Licensed Practical Nurses	16,307	17,116	419,106	24.49	4
5	CNAs & Orderlies	55,692	60,915	688,399	11.30	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,756	2,922	47,905	16.39	9
10	Activity Assistants	20,195	21,631	211,384	9.77	10
11	Social Service Workers	12,213	13,043	187,276	14.36	11
12	Dietician	6,359	6,807	70,360	10.34	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,169	20,277	208,659	10.29	15
16	Dishwashers					16
17	Maintenance Workers	35,686	37,945	357,078	9.41	17
18	Housekeepers	28,236	30,618	300,175	9.80	18
19	Laundry	4,000	4,355	41,989	9.64	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,131	2,377	28,100	11.82	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					31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	203,187	219,577	\$ 2,602,625 *	\$ 11.85	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		\$		35
36	Medical Director	Monthly	6,000	09-03	36
37	Medical Records Consultant	96	4,512	10-03	37
38	Nurse Consultant	187	11,220	10-03	38
39	Pharmacist Consultant	12	465	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	36	1,764	11-03	44
45	Social Service Consultant	196	12,427	12-03	45
46	Other(specify) Outside Labor- Dieta	2,998	54,950	01-03	46
47	Outside Labor- Social Service	4,263	103,686	12-03	47
48					48
49	TOTAL (lines 35 - 48)	7,788	\$ 195,024		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	4,632	\$ 173,767	10-03	50
51	Licensed Practical Nurses	4,281	154,555	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	8,913	\$ 328,322		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** 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? Yes
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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. \$ 302 Line 10
- (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. \$ 94,170
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? Yes 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? N/A
- (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? No 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. \$ 45,074 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? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes
- (19) 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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.