

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: 0013334

Facility Name: Sacred Heart Home Inc.

Address: 1550 S. Albany Chicago 60623
Number City Zip Code

County: Cook

Telephone Number: (773) 277-6868 Fax # (773) 277-5014

HFS ID Number:

Date of Initial License for Current Owners: 01/01/71

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☒ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider	(Signed)		(Date)
	(Type or Print Name)		
	(Title)		
Paid Preparer	(Signed)		(Date)
	(Print Name and Title)	Jeffrey K. Singer, C.P.A.	
	(Firm Name & Address)	Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015	
	(Telephone)	(847) 236-1111 Fax # (847) 236-1155	
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630		

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home Inc.

0013334 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	62,952	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	172	TOTALS	172	62,952	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	47,431	788		48,219	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,431	788		48,219	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.60%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

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

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

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

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

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

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: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number Sacred Heart Home Inc. # 0013334 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	292,676	37,742	52,533	382,951		382,951		382,951			1
2	Food Purchase		418,674		418,674	(49,465)	369,209	(68)	369,141			2
3	Housekeeping	281,483	111,597		393,080		393,080		393,080			3
4	Laundry	45,443	30,666		76,109		76,109		76,109			4
5	Heat and Other Utilities			123,704	123,704		123,704	(1,417)	122,287			5
6	Maintenance	471,044		173,316	644,360		644,360	20,145	664,505			6
7	Other (specify):*											7
8	TOTAL General Services	1,090,646	598,679	349,553	2,038,878	(49,465)	1,989,413	18,660	2,008,073			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	1,284,219	65,085	242,351	1,591,655		1,591,655		1,591,655			10
10a	Therapy			398	398		398		398			10a
11	Activities	235,736	12,020		247,756		247,756		247,756			11
12	Social Services	270,796	1,507	137,321	409,624		409,624		409,624			12
13	CNA Training											13
14	Program Transportation			15,247	15,247		15,247		15,247			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,790,751	78,612	398,317	2,267,680		2,267,680		2,267,680			16
	C. General Administration											
17	Administrative			675,782	675,782		675,782	(408,536)	267,246			17
18	Directors Fees											18
19	Professional Services			79,071	79,071		79,071	(20,353)	58,718			19
20	Dues, Fees, Subscriptions & Promotions			12,935	12,935		12,935	(242)	12,693			20
21	Clerical & General Office Expenses	47,647	31,246	83,291	162,184		162,184	74,061	236,245			21
22	Employee Benefits & Payroll Taxes			438,759	438,759	49,465	488,224		488,224			22
23	Inservice Training & Education											23
24	Travel and Seminar			332	332		332		332			24
25	Other Admin. Staff Transportation							3,495	3,495			25
26	Insurance-Prop.Liab.Malpractice			189,647	189,647		189,647	2,598	192,245			26
27	Other (specify):*							64,742	64,742			27
28	TOTAL General Administration	47,647	31,246	1,479,817	1,558,710	49,465	1,608,175	(284,235)	1,323,940			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,929,044	708,537	2,227,687	5,865,268		5,865,268	(265,575)	5,599,693			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			112,071	112,071		112,071	73,732	185,803			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			124,073	124,073		124,073	4,220	128,293			32
33	Real Estate Taxes							12,225	12,225			33
34	Rent-Facility & Grounds			188,400	188,400		188,400	(188,400)				34
35	Rent-Equipment & Vehicles			5,482	5,482		5,482		5,482			35
36	Other (specify):*			3,286	3,286		3,286	(3,286)				36
37	TOTAL Ownership			433,312	433,312		433,312	(101,509)	331,803			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			1,933	1,933		1,933		1,933			40
41	Coffee and Gift Shops		38,368		38,368		38,368	(20,484)	17,884			41
42	Provider Participation Fee			525,107	525,107		525,107		525,107			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		38,368	527,040	565,408		565,408	(20,484)	544,924			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,929,044	746,905	3,188,039	6,863,988		6,863,988	(387,568)	6,476,420			45

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

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	74,729	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	(68)	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	(15,868)	21		18
19	Entertainment	(702)	21		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	(35,057)	21		24
25	Fund Raising, Advertising and Promotional	(752)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(468)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(156,813)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (134,999)		\$	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)	(252,569)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (252,569)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (387,568)		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

Report Period Beginning:

Ending:

ID#

0013334

01/01/12

12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Additional R&M	\$ 33,051	06	1
2	Vending Income	(20,484)	41	2
3	Amortization	(3,286)	36	3
4	Bank Charges	(13,181)	21	4
5	PPA - Repairs & Maintenance	(1,879)	06	5
6	Bldg Co - Management Fees	(90,000)	17	6
7	Bldg Co - Licenses & Fees	(150)	20	7
8	Bldg Co - Penalty & Bank Charges	(1,012)	21	8
9	Bldg Co - Professional Fees	(1,753)	19	9
10	IOP Rented Space - Utilities	(2,898)	05	10
11	IOP Rented Space - Maintenance	(3,891)	06	11
12	IOP Rented Space - Insurance	(4,443)	26	12
13	IOP Rented Space - Depreciation	(5,258)	30	13
14	IOP Rented Space - Interest	(2,907)	32	14
15	IOP Rented Space -R/E Tax	(174)	33	15
16	Capitalized R&M	(10,465)	06	16
17	Non Allowable Legal	(2,746)	19	17
18	Non Allowable Professional Fees	(21,043)	19	18
19	Annual Report	(100)	20	19
20	Non Allowable Penalties/Late Fees	(4,194)	21	20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(156,813)		49

ID#0013334

Report Period Beginning:01/01/12

Ending:12/31/12

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

Summary A

12/31/12

[illegible]

Summary B

12/31/12

[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		

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	Rent	\$ 188,400	Long Term Care	100.00%	\$	(188,400)	1
2	V	26	Insurance		Long Term Care	100.00%	871	871	2
3	V	33	Real Estate Taxes		Long Term Care	100.00%	9,117	9,117	3
4	V	17	Management Fees		Long Term Care	100.00%	90,000	90,000	4
5	V	20	Licenses & Fees		Long Term Care	100.00%	150	150	5
6	V	21	Penalty & Bank Charges		Long Term Care	100.00%	1,012	1,012	6
7	V	19	Professional Fees		Long Term Care	100.00%	1,753	1,753	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 188,400			\$ 102,903	\$ * (85,497)	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	5	UTILITIES	\$	MADO MGMT. LP	100.00%	\$ 1,481	\$ 1,481	15
16	V	6	REPAIRS AND MAINT.		MADO MGMT. LP	100.00%	3,329	3,329	16
17	V	17	ADMINISTRATIVE		MADO MGMT. LP	100.00%	6,497	6,497	17
18	V	19	PROFESSIONAL FEES		MADO MGMT. LP	100.00%	3,436	3,436	18
19	V	20	DUES AND SUBSCRIPTIONS		MADO MGMT. LP	100.00%	610	610	19
20	V	21	CLERICAL AND GENERAL		MADO MGMT. LP	100.00%	143,531	143,531	20
21	V	25	AUTO EXPENSE		MADO MGMT. LP	100.00%	3,495	3,495	21
22	V	26	PROPERTY INSURANCE		MADO MGMT. LP	100.00%	6,170	6,170	22
23	V	27	GEN. ADMIN. - EMP. BEN.		MADO MGMT. LP	100.00%	31,744	31,744	23
24	V	30	DEPRECIATION		MADO MGMT. LP	100.00%	4,261	4,261	24
25	V	32	INTEREST		MADO MGMT. LP	100.00%	7,127	7,127	25
26	V	33	REAL ESTATE TAXES		MADO MGMT. LP	100.00%	3,282	3,282	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%	37,967	37,967	30
31	V	27	EMP. BEN.-P. O'BRIEN		MADO MGMT. LP	100.00%	7,184	7,184	31
32	V								32
33	V					100.00%			33
34	V	17	ADMINISTRATIVE SALARY		MADO MGMT. LP	100.00%	165,000	165,000	34
35	V	27	GEN. ADMIN. - EMP. BEN.		MADO MGMT. LP	100.00%	25,814	25,814	35
36	V	33	REAL ESTATE TAXES		MADO MGMT. LP	100.00%			36
37	V								37
38	V								38
39	Total			\$ 618,000			\$ 450,928	\$ * (167,072)	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	\$ 230,230	WINDY CITY NURSING	100.00%	\$ 230,230	\$	15
16	V	01	DIETARY	52,533	WINDY CITY NURSING	100.00%	52,533		16
17	V	21	CLERICAL	57,782	WINDY CITY NURSING	100.00%	57,782		17
18	V	12	SOCIAL SERVICES	126,996	WINDY CITY NURSING	100.00%	126,996		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			\$ 467,541			\$ 467,541	\$ *	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

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

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%	FORTY SIX TWENTY ONE CORPORATION INCORPORATED D/B/A CHICAGO		LONG TERM CARE		BUILDING CO.	1
2	MARY O'BRIEN	20.000%	MARGARET MANOR, INC.	CHICAGO	WINDY CITY NURSING (CONT.)	CHICAGO	NURSING, DIETARY, AC	2
3	PETER O'BRIEN	60.000%	NINE FORTY COLLOM CORPORATION D/B/A MARGARET MANOR	CHICAGO	MADO MANAGEMENT	CHICAGO	BOOKEEPING / MANAGI	3
4			ST. AGNES MANOR INC.	CHICAGO	WINDY CITY NURSING	CHICAGO	OUTSIDE LABOR FOR:	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	9.7	16.17%	Alloc. Salary	\$ 37,967	17-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 37,967		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: 01/01/12 Ending: 12/31/12

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

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	228,605	5	\$ 7,024	\$	48,219	\$ 1,481	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	228,605	5	15,781		48,219	3,329	2
3	17	ADMINISTRATIVE	PATIENT DAYS	228,605	5	30,800	30,800	48,219	6,497	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	228,605	5	16,292		48,219	3,436	4
5	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	228,605	5	2,891		48,219	610	5
6	21	CLERICAL AND GENERAL	PATIENT DAYS	228,605	5	680,475	622,074	48,219	143,531	6
7	25	AUTO EXPENSE	PATIENT DAYS	228,605	5	16,570		48,219	3,495	7
8	26	PROPERTY INSURANCE	PATIENT DAYS	228,605	5	29,253		48,219	6,170	8
9	27	GEN. ADMIN. - EMP. BEN.	PATIENT DAYS	228,605	5	150,496		48,219	31,744	9
10	30	DEPRECIATION	PATIENT DAYS	228,605	5	20,202		48,219	4,261	10
11	32	INTEREST	PATIENT DAYS	228,605	5	33,791		48,219	7,127	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	228,605	5	15,560		48,219	3,282	12
13										13
14										14
15										15
16	17	SALARY-P. O'BRIEN	AVG. HOURS WORKED	46	5	180,000	180,000	9.70	37,967	16
17	27	EMP. BEN.-P. O'BRIEN	AVG. HOURS WORKED	46	5	34,058		9.70	7,184	17
18										18
19										19
20	17	ADMINISTRATIVE SALARY	DIRECT ALLOCATION		5	524,587	524,587		165,000	20
21	27	GEN. ADMIN. - EMP. BEN.	DIRECT ALLOCATION		5	88,915			25,814	21
22	33	REAL ESTATE TAXES	DIRECT ALLOCATION		1	4,354				22
23										23
24										24
25	TOTALS					\$ 1,851,049	\$ 1,357,461		\$ 450,928	25

Facility Name & ID Number Sacred Heart Home Inc. # 0013334 Report Period Beginning: 01/01/12 Ending: 12/31/12

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			\$	\$		\$ 230,230	1
2	1	DIETARY	DIRECT ALLOCATION						52,533	2
3	21	CLERICAL	DIRECT ALLOCATION						57,782	3
4	12	SOCIAL SERVICES	DIRECT ALLOCATION						126,996	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					\$	\$		\$ 467,541	25

Facility Name & ID Number Sacred Heart Home Inc. # 0013334 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

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

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

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

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

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

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	Line of Credit			\$	225,800			\$ 121,166	1	
2												2	
3												3	
4												4	
5	See Supplemental Schedule											5	
	Working Capital												
6	Allocated from MADO Management		X								7,127	6	
7												7	
8	See Supplemental Schedule											8	
9	TOTAL Facility Related						\$	225,800			\$ 128,293	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			\$ 128,293	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NoneLine # 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

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	6,184	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.)				\$	10,714	2
3. Under or (over) accrual (line 2 minus line 1).				\$	4,530	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	7,695	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.				\$	12,225	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2007	4,648	8			
	2008	4,695	9			
	2009	6,959	10			
	2010	7,262	11			
	2011	7,432	12			
Beginning Accrual Adjusted						
Allocated from MADO Management = \$3,282						
2012 Accrual = \$7,432 x 1.0354						

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$	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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Sacred Heart Home Inc.</u>	COUNTY	<u>Cook</u>
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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 2011 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 2011.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>16-24-106-035-0000</u>	<u>Long Term Care Property</u>	\$ <u>970.60</u>	\$ <u>970.60</u>
2. <u>16-24-106-036-0000</u>	<u>Long Term Care Property</u>	\$ <u>1,837.30</u>	\$ <u>1,837.30</u>
3. <u>16-24-106-037-0000</u>	<u>Long Term Care Property</u>	\$ <u>4,624.15</u>	\$ <u>4,624.15</u>
4. <u>17-04-204-012-0000</u>	<u>Home Office Allocation</u>	\$ <u>22,882.17</u>	\$ <u>3,282.00</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>30,314.22</u>	\$ <u>10,714.05</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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

PLEASE NOTE: *Payment information from the Internet* or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

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

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAMESacred Heart Home Inc.COUNTYCook

FACILITY IDPH LICENSE NUMBER0013334

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)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 79,940

B. General Construction Type: Exterior Frame Number 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

Facility Name & ID Number Sacred Heart Home Inc.

0013334

Report Period Beginning:

01/01/12

Ending:

12/31/12

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
5										
6										
7										
8										
	Improvement Type**									
9	Various			1973	9,000		20			9,000
10	Various			1975	16,880		20			16,880
11	Various			1976	4,234		20			4,234
12	Various			1977	43,234		20			43,234
13	Various			1978	50,867		20			50,867
14	Various			1979	40,393		20			40,393
15	Various			1980	4,392		20			4,392
16	Various			1981	15,817		20			15,817
17	Various			1982	15,180		20			15,180
18	Various			1984	7,505		20			7,505
19	Various			1985	60,377		20			60,377
20	Various			1986	41,792		20			41,792
21	Various			1987	17,344		20			17,344
22	Various			1988	13,840		20			13,824
23	Various			1989	10,568		20			10,568
24	Various			1990	48,324		20			48,324
25	Various			1991	26,113		20			25,972
26	Various			1992	105,671		20			105,671
27	Various			1993	14,487		20			14,487
28	Various			1994	37,950		20	1,898	1,898	36,057
29	Various			1995	38,705		20	1,935	1,935	32,898
30	Various			1996	34,431		20	1,698	1,698	29,572
31	Various			1997	62,792		20	3,140	3,140	48,530
32	Various			1998	73,236		20	3,662	3,662	54,035
33	Various			1999	51,272		20	2,564	2,564	34,538
34	Various			2000	120,486		20	6,024	6,024	76,044
35	Various			2001	159,720		20	7,986	7,986	91,491
36	Various			2002	148,315		20	7,131		147,280

*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:

01/01/12

Ending:

12/31/12

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	\$ 133,306	37
38	Various	2004	159,051		20	15,905	15,905	135,727	38
39	Various	2005	156,033		20	9,221	9,221	68,381	39
40	Various	2006	173,699		20	16,147	16,147	103,404	40
41	Various	2007	134,430		20	13,268	13,268	74,441	41
42	Various	2008	72,586		20	3,629	3,629	15,996	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)		67,132	2,046		2,417	371	42,258	68
69	Financial Statement Depreciation			106,813			(106,813)		69
70	TOTAL (lines 4 thru 69)		\$ 2,316,766	\$ 108,859		\$ 110,716	\$ (5,274)	\$ 1,809,816	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:

01/01/12

Ending:

12/31/12

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		\$ 2,316,766	\$ 108,859		\$ 110,716	\$ 1,857	\$ 1,809,816	1
2	Pump Motor & Thermostatic Valve	2009	4,579		20	229	229	878	2
3	Removal & Repaving Of Courtyard	2009	7,000		20	350	350	1,254	3
4	New Layer Of Hot Roofing Rubber	2009	4,700		20	235	235	823	4
5	Doors For Resident Rooms	2009	3,352		20	168	168	573	5
6	Hot Water Heater & Installation Supplies	2009	4,564		20	228	228	780	6
7	Removal Of Fire Escape	2009	32,500		20	1,625	1,625	5,552	7
8	Brickwork For Doorways & Windows	2009	4,500		20	225	225	750	8
9	Closure Of 12 Fire Exit Doors	2009	5,056		20	253	253	843	9
10	Replaced Broken Pipe; Paved Hole - Courtyard	2009	2,943		20	147	147	466	10
11	Upgrade Boiler Room & Sewer	2009	2,548		20	127	127	403	11
12	Labor - Conversion Of Hobby Room To Activity Room	2009	5,355		20	268	268	826	12
13	Labor - Electrical Work - Nurses Station Renovation	2009	16,040		20	802	802	2,473	13
14	2Nd & 3Rd Flr Bathrooms- Tiles, Shelves, Flushometer	2009	22,471		20	1,124	1,124	4,213	14
15	Coverion Of Hobby Room To Activiy Room- Flooring, Walls, Pai	2009	4,543		20	227	227	738	15
16	2Nd Flr Nurses Station& Activity Rm- Tiles, Paint, Ceiling	2009	16,020		20	801	801	2,470	16
17	2Nd Flr Nurses Station & Bathroom- Fixtures, Paint, Doors	2009	5,690		20	284	284	948	17
18	Install & Paint Iron Fence & Gate	2009	3,900		20	195	195	618	18
19	Upgrade 2Nd Floor Nurses Station- Flooring, Wall Work	2009	7,633		20	382	382	1,209	19
20	Upgrade Courtyard Gate	2009	2,754		20	138	138	425	20
21	Installation Of Exterior Lighting - Courtyard	2009	9,875		20	494	494	1,769	21
22	2Nd Flr Nurses Station- Flooring, New Wall, Cabinets/Counter To	2009	14,621		20	731	731	2,254	22
23	2Nd & 3Rd Floor Security System - Cameras & Monitor	2010	4,872		20	244	244	690	23
24	Water Heater For Laundry	2010	4,162		20	416	416	936	24
25	Fire Alarm System Work	2010	3,400		20	170	170	368	25
26	Furnished And Installed Terrazzo Flooring	2010	4,300		20	215	215	645	26
27	Smoke Detectors & Fire Panels	2010	26,847		20	1,342	1,342	3,915	27
28	Fire Rated Doors	2010	10,594		20	530	530	1,545	28
29	Conversion Of Activity Room To Rehab Office	2010	5,843		20	292	292	828	29
30	Window Screens	2010	4,239		20	212	212	601	30
31	Compressor For Fire Pump	2010	3,705		20	185	185	525	31
32	Furnished & Installed Pedestrian Door	2010	2,828		20	141	141	401	32
33	Furnished & Replaced Broken Section Of Boiler	2010	15,125		20	756	756	2,080	33
34	TOTAL (lines 1 thru 33)		\$ 2,583,325	\$ 108,859		\$ 124,252	\$ 15,393	\$ 1,852,613	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:

01/01/12

Ending:

12/31/12

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		\$ 2,583,325	\$ 108,859		\$ 124,252	\$ 15,393	\$ 1,852,613	1
2	Electric Upgrade & Outlets For A/C	2010	28,750		20	1,438	1,438	3,833	2
3	New Central Heating & A/C Unit	2010	18,715		20	936	936	2,651	3
4	Doors & Supplies For 1St Floor Bathroom & Stairs	2010	3,611		20	181	181	466	4
5	1St Floor Bathrooms - Plumbing	2010	12,300		20	615	615	1,589	5
6	Electrical Work On 2Nd & 3Rd Floors	2010	2,875		20	144	144	359	6
7	Upgrade Fire Sprinkler System	2010	10,842		20	542	542	1,310	7
8	Floor Tiles - Iop Project	2010	7,981		20	399	399	931	8
9	Ceiling Tiles And Doors For Iop Office	2010	4,007		20	200	200	467	9
10	Electrical Work For Iop Office	2010	5,075		20	254	254	571	10
11	New Hvac For Iop Office	2010	6,220		20	311	311	700	11
12	Upgrade Electrical Panel	2010	4,587		20	229	229	516	12
13	Bathroom Renovation - Walls, Plumbing, Showers, Tubs, Lighting	2010	72,577		20	3,629	3,629	7,560	13
14	Iop Office Conversion - Demolition, Drywall, Electrical, Flooring,	2010	78,375		20	3,919	3,919	8,164	14
15	Iop Office Bathroom - Doors & Supplies	2010	3,492		20	175	175	407	15
16	Sprinkler Head Installations	2010	2,945		20	147	147	319	16
17	2Nd Floor Bathrooms - Frame, Drywall, Floor, Tile, Shower Pan,	2011	14,741		20	737	737	1,413	17
18	3Rd Floor Bathrooms - Frame, Drywall, Floor, Tile, Shower Pan,	2011	5,231		20	262	262	501	18
19	Janitor Closets - New Pipes, Walls, Tile, Sinks	2011	13,358		20	668	668	1,224	19
20	Reception & Conference Rm - Walls, Doors, Duct Work, Tile, Cab	2011	33,828		20	3,383	3,383	6,202	20
21	3Rd Floor Tiage Unit - Walls, Floor, Electrical Fixtures, Doors, Si	2011	116,104		20	5,805	5,805	7,740	21
22	Fire Sprinklers - Elevator	2011	5,884		20	294	294	515	22
23	Fire Sprinklers - Reception & Lounge	2011	3,077		20	154	154	269	23
24	Additional Fire Sprinklers For State Compliance	2011	6,722		20	336	336	560	24
25	Fire Sprinklers - Janitor Closets	2011	3,716		20	186	186	310	25
26	Fire Sprinklers - Canopy	2011	2,708		20	135	135	226	26
27	New Windows	2011	6,924		20	346	346	490	27
28	Fire Sprinklers - Triage	2011	6,266		20	313	313	339	28
29	Transitional Living Unit - Vents, Drains, Sewer Connect, Window	2011	89,875		20	4,494	4,494	8,613	29
30	Transitional Unit Construction Drawing & Permit	2011	13,959		20	698	698	814	30
31	Transitional Care Unit - Electrical Wiring	2012	32,285		20	1,211	1,211	1,211	31
32	Transitional Care Unit - Fire Sprinkler System	2012	34,224		20	998	998	998	32
33	Transitional Care Unit - Plumbing & Hvac	2012	10,014		20	292	292	292	33
34	TOTAL (lines 1 thru 33)		\$ 3,244,593	\$ 108,859		\$ 157,681	\$ 48,822	\$ 1,914,176	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:

01/01/12

Ending:

12/31/12

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		\$ 3,244,593	\$ 108,859		\$ 157,681	\$ 48,822	\$ 1,914,176	1
2	Transitional Care Unit - Labor & Materials	2012	98,849		20	2,883	2,883	2,883	2
3	Transitional Care Unit - Doors	2012	9,580		20	359	359	359	3
4	Transitional Care Unit - Paint, Floor Tile, Adhesive Materials	2012	5,395		20	225	225	225	4
5	Transitional Care Unit - Fire Protection Windows	2012	4,285		20	250	250	250	5
6	Transitional Care Unit - Additional Materials, Hvac, Lighting, Do	2012	39,920		20	333	333	333	6
7	Water Heater	2012	9,865		20	740	740	740	7
8	Granite Kitchen Top & Sink	2012	2,950		20	123	123	123	8
9	Gas Pipes To Range Hood	2012	8,500		20	283	283	283	9
10	Replace Hydraulic Valve	2012	2,638		20	132	132	132	10
11	Elevator Repair - Head Gaskets & Hydraulic Packing	2012	2,927		20	146	146	146	11
12	Roofing Work - South & Northwest Roof Of Bldg	2012	4,900		20	245	245	245	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)		\$ 3,434,402	\$ 108,859		\$ 163,400	\$ 54,541	\$ 1,919,895	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 12D, Carried Forward		\$3,434,402	\$108,859		\$163,400	\$54,541	\$1,919,895	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)		\$3,434,402	\$108,859		\$163,400	\$54,541	\$1,919,895	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					35				3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9					20				9
10					20				10
11					20				11
12					20				12
13					20				13
14					20				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.

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

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)		\$67,132	\$2,046		\$2,417	\$371	\$42,258	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	\$264,030	\$87	\$14,820	\$14,733	10	\$196,340	71
72	Current Year Purchases	38,939		2,300	2,300	10	2,300	72
73	Fully Depreciated Assets	222,652		240	240	10	220,236	73
74								74
75	TOTALS	\$525,622	\$87	\$17,360	\$17,273		\$418,876	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	2012	43,382	2,129	5,044	2,915	5	37,052	77
78										78
79										79
80	TOTALS			\$67,839	\$2,129	\$5,044	\$2,915		\$61,508	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)	\$4,049,940	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$111,075	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$185,804	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$74,729	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,400,279	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.

		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: \$5,482
- 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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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)	\$			

- (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.

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	

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	2	3	4		6	7	8	
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	N/A	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 25,324	\$ 25,554	1
2	Cash-Patient Deposits	99	99	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,047,746	1,047,746	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,947	21,947	6
7	Other Prepaid Expenses	475	475	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	14,174	14,174	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,109,765	\$ 1,109,995	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	2,705,455	2,705,455	15
16	Equipment, at Historical Cost	680,718	695,718	16
17	Accumulated Depreciation (book methods)	(1,877,016)	(2,032,016)	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	650,595	3,211,676	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,159,752	\$ 4,736,698	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,269,517	\$ 5,846,693	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,211,900	\$ 1,216,096	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,032	11,032	28
29	Short-Term Notes Payable	225,800	225,800	29
30	Accrued Salaries Payable	9,644	9,644	30
31	Accrued Taxes Payable (excluding real estate taxes)	745	745	31
32	Accrued Real Estate Taxes(Sch.IX-B)		7,695	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes		(106)	35
	Other Current Liabilities(specify):			
36	See Attached Schedule			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,459,121	\$ 1,470,906	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)	\$ 1,459,121	\$ 1,470,906	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,810,396	\$ 4,375,787	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,269,517	\$ 5,846,693	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$2,409,414	1
2	Restatements (describe):		2
3	Adjusting Journal Entries	(156,028)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$2,253,386	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(442,990)	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)	\$(442,990)	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)	\$1,810,396	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,286,343	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,286,343	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	20,484	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)	\$ 134,655	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	See Supplemental Schedule		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)	\$ 6,420,998	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,038,878	31
32	Health Care	2,267,680	32
33	General Administration	1,558,710	33
	B. Capital Expense		
34	Ownership	433,312	34
	C. Ancillary Expense		
35	Special Cost Centers	40,301	35
36	Provider Participation Fee	525,107	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,863,988	40
41	Income before Income Taxes (line 30 minus line 40)**	(442,990)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (442,990)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 6,185,267	44
45	Private Pay - Net Inpatient Revenue	101,076	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,286,343	49

* 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.

****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	1,175	1,236	33,991	27.50	3
4	Licensed Practical Nurses	18,435	19,479	471,682	24.21	4
5	CNAs & Orderlies	62,531	67,852	778,546	11.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,520	2,712	44,740	16.50	9
10	Activity Assistants	17,846	19,118	190,996	9.99	10
11	Social Service Workers	16,720	17,708	270,796	15.29	11
12	Dietician	4,451	4,759	54,148	11.38	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,916	23,404	238,528	10.19	15
16	Dishwashers					16
17	Maintenance Workers	42,784	46,187	471,044	10.20	17
18	Housekeepers	25,975	28,343	281,483	9.93	18
19	Laundry	4,157	4,613	45,443	9.85	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,589	4,222	47,647	11.29	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)	221,099	239,633	\$ 2,929,044 *	\$ 12.22	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	3,000	09-03	36
37	Medical Records Consultant	72	3,384	10-03	37
38	Nurse Consultant	90	5,400	10-03	38
39	Pharmacist Consultant	12	600	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				44
45	Social Service Consultant		10,325	12-03	45
46	Other(specify) Outside Labor-Dietar	2,885	52,533	01-03	46
47	Outside Labor- Social Service	4,810	126,996	12-03	47
48	Rehab Consultant	1	398	10a-03	48
49	TOTAL (lines 35 - 48)	7,870	\$ 202,636		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	5,368	\$ 207,079	10-03	50
51	Licensed Practical Nurses	720	25,888	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	6,088	\$ 232,967		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number		Sacred Heart Home Inc.		STATE OF ILLINOIS		# 0013334		Report Period Beginning:		01/01/12		Page 21		Ending:		12/31/12	
XIX. SUPPORT SCHEDULES																	
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions									
Name		Function		Ownership %		Amount		Description		Amount		Description		Amount			
						\$		Workers' Compensation Insurance		\$ 131,691		IDPH License Fee		\$ 1,990			
								Unemployment Compensation Insurance				Advertising: Employee Recruitment		98			
								FICA Taxes		224,072		Health Care Worker Background Check					
								Employee Health Insurance		82,752		(Indicate # of checks performed 55)		550			
								Employee Meals		49,465		Patient Background Checks 143		3,960			
								Illinois Municipal Retirement Fund (IMRF)*				Licenses, Dues & Fees		5,485			
								401K- Employer's		244		Allocated from MADO Management		610			
TOTAL (agree to Schedule V, line 17, col. 1)																	
(List each licensed administrator separately.)				\$													
B. Administrative - Other																	
Description		Amount										Less: Public Relations Expense		()			
Management Fees - MADO Management		\$ 618,000										Non-allowable advertising		()			
Outside Labor - Assistant Administrator		57,782										Yellow page advertising		()			
TOTAL (agree to Schedule V, line 17, col. 3)		\$ 675,782						TOTAL (agree to Schedule V, line 22, col.8)		\$ 488,224		TOTAL (agree to Sch. V, line 20, col. 8)		\$ 12,693			
(Attach a copy of any management service agreement)																	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**									
Vendor/Payee		Type		Amount		Description		Line #		Amount		Description		Amount			
Legal		Adj Pg 5a		\$ 2,746						\$		Out-of-State Travel		\$			
Misc Professional Fees		Adj Pg 5a		21,043													
Frost, Ruttenberg & Rothblatt		Accounting		12,855													
Personnel Planners		Unemployment Consult		3,014								In-State Travel					
Wolf & Company		Accounting		5,598													
Maemar P.C.		Architect		1,598													
Life Safety Resources, LLC		Consultant		6,448													
Michael Vernali		Program Consultant		14,500								Seminar Expense		332			
HDSI		Data Processing		11,271													
TOTAL (agree to Schedule V, line 19, column 3)						TOTAL				\$		Entertainment Expense		()			
(If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 79,073								(agree to Sch. V, line 24, col. 8)					
												TOTAL 332					

* 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?

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.

\$107

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.

\$525,107

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.

(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.

\$49,465

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.
- SEE ACCOUNTANTS' COMPILATION REPORT