

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: <u>0013334</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																	
Facility Name: <u>Sacred Heart Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/16</u> to <u>12/31/16</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																																																	
Address: <u>1550 South Albany</u> <u>Chicago</u> <u>60623</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																																	
County: <u>Cook</u>																																																			
Telephone Number: <u>(773) 277-6868</u> Fax # <u>(773) 277-5014</u>																																																			
HFS ID Number: _____																																																			
Date of Initial License for Current Owners: <u>02/01/1971</u>																																																			
Type of Ownership:																																																			
<table><tr><td>☐</td><td>VOLUNTARY,NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☒</td><td>"Sub-S" Corp.</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Limited Liability Co.</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2"></td></tr></table>		☐	VOLUNTARY,NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☒	"Sub-S" Corp.					☐	Limited Liability Co.					☐	Trust					☐	Other _____				
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		☐	Trust																																																
		☐	Other _____																																																
In the event there are further questions about this report, please contact:																																																			
Name: <u>PETER O'BRIEN</u>																																																			
Telephone Number: <u>(312) 787-9400</u>																																																			
Email Address: _____																																																			
		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____																																																	
		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>CAMILLE B. LOCKHART</u> <u>PARTNER</u> (Firm Name & Address) <u>BKD, LLP</u> <u>P. O. BOX 1190, SPRINGFIELD, MO 65801-1190</u> (Telephone) <u>(417) 865-8701</u> Fax # <u>(417) 865-0682</u>																																																	
		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																																																	

Facility Name & ID Number Sacred Heart Home

0013334 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 _____

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
4		Intermediate/DD		4
5		Sheltered Care (SC)		5
6		ICF/DD 16 or Less		6
7	172	TOTALS	172	62,952

B. Census-For the entire report period.

1	2	3	4	5	
Level of Care	Patient Days by Level of Care and Primary Source of Payment				
	Medicaid Recipient	Private Pay	Other	Total	
8	SNF				8
9	SNF/PED				9
10	ICF	53,401	470	118	53,989
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	53,401	470	118	53,989

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.76%

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 Date NO X

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

IV. ACCOUNTING BASIS

MODIFIED ACCRUAL X CASH* CASH*

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

Tax Year: 1/1/16 Fiscal Year: 12/31/16

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

Facility Name & ID Number Sacred Heart Home # 0013334 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	295,192	23,472		318,664		318,664		318,664			1
2	Food Purchase		296,034		296,034	(35,524)	260,510	(247)	260,263			2
3	Housekeeping	249,856	53,114		302,970		302,970		302,970			3
4	Laundry	50,375	36,188		86,563		86,563		86,563			4
5	Heat and Other Utilities			89,120	89,120		89,120	(1,425)	87,695			5
6	Maintenance	100,242		209,644	309,886		309,886	(20,432)	289,454			6
7	Other (specify):*	394,930			394,930		394,930		394,930			7
8	TOTAL General Services	1,090,595	408,808	298,764	1,798,167	(35,524)	1,762,643	(22,104)	1,740,539			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,207,023	49,856	1,200	1,258,079		1,258,079		1,258,079			10
10a	Therapy											10a
11	Activities	232,697	8,930	28,682	270,309		270,309	(5,130)	265,179			11
12	Social Services	365,821	1,371	14,470	381,662		381,662		381,662			12
13	CNA Training											13
14	Program Transportation			11,910	11,910		11,910		11,910			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,805,541	60,157	62,262	1,927,960		1,927,960	(5,130)	1,922,830			16
	C. General Administration											
17	Administrative	52,521		821,600	874,121		874,121	(589,018)	285,103			17
18	Directors Fees											18
19	Professional Services			98,622	98,622		98,622	(7,330)	91,292			19
20	Dues, Fees, Subscriptions & Promotions			42,105	42,105		42,105	(37)	42,068			20
21	Clerical & General Office Expenses	256,884	35,407	30,304	322,595		322,595	391,824	714,419			21
22	Employee Benefits & Payroll Taxes			502,152	502,152	35,524	537,676		537,676			22
23	Inservice Training & Education			1,801	1,801		1,801		1,801			23
24	Travel and Seminar			9,414	9,414		9,414	(4,894)	4,520			24
25	Other Admin. Staff Transportation							2,051	2,051			25
26	Insurance-Prop.Liab.Malpractice			263,504	263,504		263,504	(393)	263,111			26
27	Other (specify):*							71,407	71,407			27
28	TOTAL General Administration	309,405	35,407	1,769,502	2,114,314	35,524	2,149,838	(136,390)	2,013,448			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,205,541	504,372	2,130,528	5,840,441		5,840,441	(163,624)	5,676,817			29

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

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

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			73,740	73,740		73,740	79,859	153,599			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			100,979	100,979		100,979	10,082	111,061			32
33	Real Estate Taxes							13,156	13,156			33
34	Rent-Facility & Grounds			300,000	300,000		300,000	(300,000)				34
35	Rent-Equipment & Vehicles			4,171	4,171		4,171		4,171			35
36	Other (specify):*											36
37	TOTAL Ownership			478,890	478,890		478,890	(196,903)	281,987			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		26,864		26,864		26,864		26,864			39
40	Barber and Beauty Shops			2,232	2,232		2,232		2,232			40
41	Coffee and Gift Shops		18,367		18,367		18,367	(16,168)	2,199			41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		45,231	2,232	47,463		47,463	(16,168)	31,295			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,205,541	549,603	2,611,650	6,366,794		6,366,794	(376,695)	5,990,099			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				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	(247)	02		13
14	Non-Care Related Interest	(1,390)	32		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	(2,350)	21		18
19	Entertainment	(4,894)	24		19
20	Contributions	(1,999)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(18,828)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(607)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,699)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	4,639			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (27,375)		\$	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)	(349,320)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (349,320)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (376,695)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MISC INCOME	\$ (7,627)	21	1
2	VENDING MACHINE	(1,994)	41	2
3	BANK CHARGES	(1,429)	21	3
4	MISC-CLIENT CLOTHING	(4,099)	21	4
5	ACTIVITY-CIGARETTES	(5,130)	11	5
6	CIGARETTE PURCHASES	(14,174)	41	6
7	ADJ DEPR TO S/L DEPR	79,017	30	7
8	IOP RENTED SPACE-UTILITIES	(2,898)	5	8
9	IOP RENTED SPACE-MAINTENANCE	(3,891)	6	9
10	IOP RENTED SPACE-INSURANCE	(4,443)	26	10
11	IOP RENTED SPACE-DEPRECIATION	(5,258)	30	11
12	IOP RENTED SPACE-INTEREST	(2,907)	32	12
13	IOP RENTED SPACE-R/E TAXES	(174)	33	13
14	CAPITALIZED R&M	(20,354)	6	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	4,639		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sacred Heart Home # 0013334 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(247)	0	0	0	0	0	0	0	0	0	0	(247)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(2,898)	0	1,473	0	0	0	0	0	0	0	0	(1,425)	5
6	Maintenance	(24,245)	0	3,813	0	0	0	0	0	0	0	0	(20,432)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(27,390)	0	5,286	0	0	0	0	0	0	0	0	(22,104)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(5,130)	0	0	0	0	0	0	0	0	0	0	(5,130)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(5,130)	0	0	0	0	0	0	0	0	0	0	(5,130)	16
	C. General Administration													
17	Administrative	0	0	(589,018)	0	0	0	0	0	0	0	0	(589,018)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(18,828)	0	11,498	0	0	0	0	0	0	0	0	(7,330)	19
20	Fees, Subscriptions & Promotions	(607)	0	570	0	0	0	0	0	0	0	0	(37)	20
21	Clerical & General Office Expenses	(19,203)	0	411,027	0	0	0	0	0	0	0	0	391,824	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(4,894)	0	0	0	0	0	0	0	0	0	0	(4,894)	24
25	Other Admin. Staff Transportation	0	0	2,051	0	0	0	0	0	0	0	0	2,051	25
26	Insurance-Prop.Liab.Malpractice	(4,443)	0	4,050	0	0	0	0	0	0	0	0	(393)	26
27	Other (specify):*	0	0	71,407	0	0	0	0	0	0	0	0	71,407	27
28	TOTAL General Administration	(47,975)	0	(88,415)	0	0	0	0	0	0	0	0	(136,390)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(80,495)	0	(83,129)	0	0	0	0	0	0	0	0	(163,624)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sacred Heart Home # 0013334 Report Period Beginning: 1/1/16 Ending: 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	73,759	0	6,100	0	0	0	0	0	0	0	0	79,859	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,297)	0	14,379	0	0	0	0	0	0	0	0	10,082	32
33	Real Estate Taxes	(174)	7,319	6,011	0	0	0	0	0	0	0	0	13,156	33
34	Rent-Facility & Grounds	0	(300,000)	0	0	0	0	0	0	0	0	0	(300,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	69,288	(292,681)	26,490	0	0	0	0	0	0	0	0	(196,903)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(16,168)	0	0	0	0	0	0	0	0	0	0	(16,168)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(16,168)	0	0	0	0	0	0	0	0	0	0	(16,168)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(27,375)	(292,681)	(56,639)	0	0	0	0	0	0	0	0	(376,695)	45

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
PETER O'BRIEN	100	MARGARET MANOR, INC.	CHICAGO	Long Term Care LP	CHICAGO	REAL ESTATE
		MARGARET MANOR NORTH	CHICAGO	Mado Management	CHICAGO	BOOKKEEPING/M
		ST. MARTHA'S MANOR	CHICAGO			

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	\$ 300,000	Long Term Care LP	100.00%	\$	(300,000)	1
2	V	33	Real Estate Tax		Long Term Care LP	100.00%	7,319	7,319	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 300,000			\$ 7,319	\$ * (292,681)	14

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

VII. RELATED PARTIES (continued)

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

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	\$	Mado Management	100.00%	\$ 1,473	\$ 1,473	15
16	V	6	Repairs & Maintenance		Mado Management	100.00%	3,813	3,813	16
17	V	19	Professional Fees		Mado Management	100.00%	11,498	11,498	17
18	V	20	Dues and Subscriptions		Mado Management	100.00%	570	570	18
19	V	21	Clerical and General		Mado Management	100.00%	411,027	411,027	19
20	V	25	Auto Expense		Mado Management	100.00%	2,051	2,051	20
21	V	26	Insurance		Mado Management	100.00%	4,050	4,050	21
22	V	27	Employee Benefits		Mado Management	100.00%	48,235	48,235	22
23	V	30	Depreciation		Mado Management	100.00%	6,100	6,100	23
24	V	32	Interest		Mado Management	100.00%	14,379	14,379	24
25	V	33	Real Estate Taxes		Mado Management	100.00%	6,011	6,011	25
26	V								26
27	V	17	Management Fees	718,000	Mado Management	100.00%		(718,000)	27
28	V								28
29	V	17	Salary - P. O'Brien		Mado Management	100.00%	73,632	73,632	29
30	V	27	Employee Benefits		Mado Management	100.00%	6,034	6,034	30
31	V								31
32	V	17	Administrative Salary		Mado Management	100.00%	55,350	55,350	32
33	V	27	Employee Benefits		Mado Management	100.00%	17,138	17,138	33
34	V								34
35	V	17	Administrative Salary	103,600	Mado Management	100.00%	103,600		35
36	V								36
37	V								37
38	V								38
39	Total			\$ 821,600			\$ 764,961	\$ * (56,639)	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			\$			\$	\$	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			\$			\$ 0	\$ *	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.

YESNO

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			\$			\$0	\$*	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.

YESNO

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			\$			\$0	\$*	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			\$			\$	\$	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			\$			\$ 0	\$ *	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.

YESNO

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			\$			\$0	\$*	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.

YESNO

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			\$			\$0	\$*	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			\$			\$	\$	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			\$			\$ 0	\$ *	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.

YESNO

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			\$			\$0	\$*	39

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

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

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Sacred Heart Home # 0013334 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	ADMINISTRATIV	100.00	SEE ATTACHED	14.11	23.52	ALLOC SAL	\$ 73,632	17-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 73,632		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# 0013334

Report Period Beginning:

1/1/16Ending: 12/31/16

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 MANAGEMENT

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, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	5	Utilities	Patient Days	4	\$ 4,800	\$	53,989	\$ 1,473	1
2	6	Repair & Maintenance	Patient Days	4	12,430		53,989	3,813	2
3	19	Professional Fees	Patient Days	4	37,480		53,989	11,498	3
4	20	Dues and Subscriptions	Patient Days	4	1,859		53,989	570	4
5	21	Clerical and General	Patient Days	4	1,339,788	1,305,092	53,989	411,027	5
6	25	Auto Expense	Patient Days	4	6,686		53,989	2,051	6
7	26	Insurance	Patient Days	4	13,203		53,989	4,050	7
8	27	Employee Benefits	Patient Days	4	157,228		53,989	48,235	8
9	30	Depreciation	Patient Days	4	19,885		53,989	6,100	9
10	32	Interest	Patient Days	4	46,871		53,989	14,379	10
11	33	Real Estate Taxes	Patient Days	4	19,592		53,989	6,011	11
12									12
13	17	Salary - P. O'Brien	Avg Hrs Worked	4	240,000	240,000		73,632	13
14	27	Employee Benefits	Avg Hrs Worked	4	19,669			6,034	14
15									15
16	17	Administrative Salary	Direct Allocation		94,308	94,308		55,350	16
17	27	Employee Benefits	Direct Allocation		50,704			17,138	17
18									18
19	17	Administrative Salary	Direct Allocation		103,600	103,600		103,600	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 2,168,103	\$ 1,743,000		\$ 764,961	25

Facility Name & ID Number Sacred Heart Home # 0013334 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 # 0013334 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 # 0013334 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 # 0013334 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 # 0013334 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 # 0013334 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 # 0013334 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 # 0013334 Report Period Beginning: 1/1/16 Ending: 12/31/16

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 # 0013334 Report Period Beginning: 1/1/16 Ending: 12/31/16

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							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	BRIDGEVIEW		X	LINE OF CREDIT				710,800				61,781	6
7	SIGNATURE		X	LINE OF CREDIT				352,046				37,808	7
8													8
9	TOTAL Facility Related						\$	1,062,846				\$ 99,589	9
	B. Non-Facility Related*												
10	RE TAX INTEREST		X									1,390	10
11													11
12													12
13	ALLOC FROM MADO MGT	X										14,379	13
14	TOTAL Non-Facility Related						\$					\$ 15,769	14
15	TOTALS (line 9+line14)						\$	1,062,846				\$ 115,358	15

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

* 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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2015 report.			\$	7,500	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.)			\$	13,239	2
3. Under or (over) accrual (line 2 minus line 1).			\$	5,739	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	7,591	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.			\$	13,330	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	7,432	8	
		2012	6,908	9	
		2013	7,002	10	
		2014	7,142	11	
		2015	7,228	12	
Allocated from MADO Management = \$6,011					
Diff with Sch V Line 33 - \$13,330 less RE adj for rental \$174 = \$13,156					
		FOR BHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2015	\$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sacred Heart Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0013334

CONTACT PERSON REGARDING THIS REPORT PETER O'BRIEN

TELEPHONE (312) 787-9400 FAX #: (312) 787-9434

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(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</u>	<u></u>	\$ <u>1,230.50</u>	\$ <u>1,230.50</u>
2. <u>16-24-106-036</u>	<u></u>	\$ <u>2,338.01</u>	\$ <u>2,338.01</u>
3. <u>16-24-106-037</u>	<u></u>	\$ <u>3,660.32</u>	\$ <u>3,660.32</u>
4. <u>17-04-204-012</u>	<u>Home Office (see attachment)</u>	\$ <u>28,812.11</u>	\$ <u>6,010.61</u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u><u>36,040.94</u></u>	\$ <u><u>13,239.44</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

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 Bureau of Health Finance at (217) 782-1630.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAMESacred Heart HomeCOUNTYCook

FACILITY IDPH LICENSE NUMBER0013334

CONTACT PERSON REGARDING THIS REPORTPETER O'BRIEN

TELEPHONE ()FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(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 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.

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).

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

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			37,950
29	Various			1995	38,705		20			38,703
30	Various			1996	34,431		20			34,431
31	Various			1997	62,792		20	3,140	3,140	61,090
32	Various			1998	73,236		20	3,662	3,662	68,683
33	Various			1999	51,272		20	2,564	2,564	44,794
34	Various			2000	120,486		20	6,024	6,024	100,140
35	Various			2001	159,720		20	7,986	7,986	123,435
36	Various			2002	148,315		20			148,315

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

1/1/16

Ending:

12/31/16

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	
37	Various	2003	\$ 140,910	\$	10	\$	\$	\$ 140,910	37
38	Various	2004	159,051		10			159,051	38
39	Various	2005	156,033		Various	9,221	9,221	105,265	39
40	Various	2006	173,699		Various	16,147	16,147	167,992	40
41	Various	2007	134,430		10	13,443	13,443	128,038	41
42	Various	2008	72,586		20	3,629	3,629	30,512	42
43	Pump Motor & Thermostatic Valve	2009	4,579		20	229	229	1,794	43
44	Removal & Repaving Of Courtyard	2009	7,000		20	350	350	2,654	44
45	New Layer Of Hot Roofing Rubber	2009	4,700		20	235	235	1,763	45
46	Doors For Resident Rooms	2009	3,352		20	168	168	1,245	46
47	Hot Water Heater & Installation Supplies	2009	4,564		20	228	228	1,692	47
48	Removal Of Fire Escape	2009	32,500		20	1,625	1,625	12,052	48
49	Brickwork For Doorways & Windows	2009	4,500		20	225	225	1,650	49
50	Closure Of 12 Fire Exit Doors	2009	5,056		20	253	253	1,855	50
51	Replaced Broken Pipe; Paved Hole - Courtyard	2009	2,943		20	147	147	1,054	51
52	Upgrade Boiler Room & Sewer	2009	2,548		20	127	127	911	52
53	Labor - Conversion Of Hobby Room To Activity Room	2009	5,355		20	268	268	1,898	53
54	Labor - Electrical Work - Nurses Station Renovation	2009	16,040		20	802	802	5,681	54
55	2Nd & 3Rd Flr Bathrooms- Tiles, Shelves, Flushometer	2009	22,471		20	1,124	1,124	8,709	55
56	Conversion Of Hobby Room To Activiy Room- Flooring, Walls, Pai	2009	4,543		20	227	227	1,646	56
57	2Nd Flr Nurses Station& Activity Rm- Tiles, Paint, Ceiling	2009	16,020		20	801	801	5,674	57
58	2Nd Flr Nurses Station & Bathroom- Fixtures, Paint, Doors	2009	5,690		20	285	285	2,087	58
59	Install & Paint Iron Fence & Gate	2009	3,900		20	195	195	1,398	59
60	Upgrade 2Nd Floor Nurses Station- Flooring, Wall Work	2009	7,633		20	382	382	2,737	60
61	Upgrade Courtyard Gate	2009	2,754		20	138	138	977	61
62	Installation Of Exterior Lighting - Courtyard	2009	9,875		20	494	494	3,745	62
63	2Nd Flr Nurses Station- Flooring, New Wall, Cabinets/Counter To	2009	14,621		20	731	731	5,178	63
64	2Nd & 3Rd Floor Security System - Cameras & Monitor	2010	4,872		20	244	244	1,666	64
65	Water Heater For Laundry	2010	4,162		10	416	416	2,600	65
66	Fire Alarm System Work	2010	3,400		20	170	170	1,048	66
67	Furnished And Installed Terrazzo Flooring	2010	4,300		20	215	215	1,505	67
68	Smoke Detectors & Fire Panels	2010	26,847		20	1,342	1,342	9,283	68
69	Fire Rated Doors	2010	10,594		20	530	530	3,665	69
70	TOTAL (lines 4 thru 69)		\$ 2,484,453	\$		\$ 77,767	\$ 77,767	\$ 2,161,334	70

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

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

1/1/16

Ending:

12/31/16

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		\$ 2,484,453	\$		\$ 77,767	\$ 77,767	\$ 2,161,334	1
2	Conversion Of Activity Room To Rehab Office	2010	5,843		20	292	292	1,996	2
3	Window Screens	2010	4,239		20	212	212	1,449	3
4	Compressor For Fire Pump	2010	3,705		20	185	185	1,265	4
5	Furnished & Installed Pedestrian Door	2010	2,828		20	141	141	965	5
6	Furnished & Replaced Broken Section Of Boiler	2010	15,125		20	756	756	5,104	6
7	Electric Upgrade & Outlets For A/C	2010	28,750		20	1,438	1,438	9,585	7
8	New Central Heating & A/C Unit	2010	18,715		20	936	936	6,395	8
9	Doors & Supplies For 1St Floor Bathroom & Stairs	2010	3,611		20	181	181	1,190	9
10	1St Floor Bathrooms - Plumbing	2010	12,300		20	615	615	4,049	10
11	Electrical Work On 2Nd & 3Rd Floors	2010	2,875		20	144	144	935	11
12	Upgrade Fire Sprinkler System	2010	10,842		20	542	542	3,478	12
13	Floor Tiles - Iop Project	2010	7,981		20	399	399	2,527	13
14	Ceiling Tiles And Doors For Iop Office	2010	4,007		20	200	200	1,267	14
15	Electrical Work For Iop Office	2010	5,075		20	254	254	1,587	15
16	New Hvac For Iop Office	2010	6,220		20	311	311	1,944	16
17	Upgrade Electrical Panel	2010	4,587		20	229	229	1,432	17
18	Bathroom Renovation - Walls, Plumbing, Showers, Tubs, Lighting	2010	72,577		20	3,629	3,629	22,076	18
19	Iop Office Conversion - Demolition, Drywall, Electrical, Flooring,	2010	78,375		20	3,919	3,919	23,840	19
20	Iop Office Bathroom - Doors & Supplies	2010	3,492		20	175	175	1,107	20
21	Sprinkler Head Installations	2010	2,945		20	147	147	907	21
22	2Nd Floor Bathrooms - Frame, Drywall, Floor, Tile, Shower Pan, I	2011	14,741		20	737	737	4,361	22
23	3Rd Floor Bathrooms - Frame, Drywall, Floor, Tile, Shower Pan, I	2011	5,231		20	262	262	1,549	23
24	Janitor Closets - New Pipes, Walls, Tile, Sinks	2011	13,358		20	668	668	3,896	24
25	Reception & Conference Rm - Walls, Doors, Duct Work, Tile, Cab	2011	33,828		10	3,383	3,383	19,734	25
26	3Rd Floor Triage Unit - Walls, Floor, Electrical Fixtures, Doors, Si	2011	116,104		20	5,805	5,805	30,960	26
27	Fire Sprinklers - Elevator	2011	5,884		20	294	294	1,691	27
28	Fire Sprinklers - Reception & Lounge	2011	3,077		20	154	154	885	28
29	Additional Fire Sprinklers For State Compliance	2011	6,722		20	336	336	1,904	29
30	Fire Sprinklers - Janitor Closets	2011	3,716		20	186	186	1,054	30
31	Fire Sprinklers - Canopy	2011	2,708		20	135	135	766	31
32	New Windows	2011	6,924		20	346	346	1,874	32
33	Fire Sprinklers - Triage	2011	6,266		20	313	313	1,591	33
34	TOTAL (lines 1 thru 33)		\$ 2,997,104	\$		\$ 105,091	\$ 105,091	\$ 2,324,697	34

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

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

1/1/16

Ending:

12/31/16

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		\$ 2,997,104	\$		\$ 105,091	\$ 105,091	\$ 2,324,697	1
2	Transitional Living Unit - Vents, Drains, Sewer Connect, Window	2011	89,875		20	4,494	4,494	26,589	2
3	Transitional Unit Construction Drawing & Permit	2011	13,959		20	698	698	3,606	3
4	Transitional Care Unit - Electrical Wiring	2012	32,285		Various	1,614	1,614	7,668	4
5	Transitional Care Unit - Fire Sprinkler System	2012	34,224		Various	1,711	1,711	7,842	5
6	Transitional Care Unit - Plumbing & Hvac	2012	10,014		Various	501	501	2,295	6
7	Transitional Care Unit - Labor & Materials	2012	98,849		Various	4,798	4,798	22,075	7
8	Transitional Care Unit - Doors	2012	9,580		27	355	355	1,885	8
9	Transitional Care Unit - Paint, Floor Tile, Adhesive Materials	2012	5,395		24	225	225	1,159	9
10	Transitional Care Unit - Fire Protection Windows	2012	4,285		Various	202	202	1,058	10
11	Transitional Care Unit - Additional Materials, Hvac, Lighting, Do	2012	39,920		Various	1,979	1,979	8,249	11
12	Water Heater	2012	9,865		Various	456	456	2,564	12
13	Granite Kitchen Top & Sink	2012	2,950		Various	141	141	687	13
14	Gas Pipes To Range Hood	2012	8,500		Various	411	411	1,927	14
15	Replace Hydraulic Valve	2012	2,638		20	132	132	653	15
16	Elevator Repair - Head Gaskets & Hydraulic Packing	2012	2,927		20	146	146	723	16
17	Roofing Work - South & Northwest Roof Of Bldg	2012	4,900		20	245	245	1,213	17
18	Addressable Fire Alarm System	2013	4,300		7	614	614	2,354	18
19	MATERIALS TO MAINTAIN 2ND FLOOR - ILP	2013	2,534		20	127	127	487	19
20	SUPPLIES FOR MAINTENANCE-ILP;TRIAGE,RESIDENTS' R	2013	2,639		20	132	132	462	20
21	MATERIALS FOR 2ND FLOOR; RESIDENTS' ROOM REPAIR	2013	2,759		20	138	138	540	21
22	FURNISHED & INSTALLED ONE NEW 230 VOLT IMPERIAL	2013	2,823		20	141	141	447	22
23	MATERIALS FOR 1ST FLOOR;BUILT 4 RESIDENTS BED&SI	2013	3,440		20	172	172	588	23
24	BATTERIES, TILE CEILINGS, FLOOR TILES; ELECTRICAL	2013	4,747		20	237	237	751	24
25	MATERIALS TO MAINTAIN-COURTYARD,TRIAGE&AROU	2013	5,776		20	289	289	1,035	25
26	FURNITURE	2013	2,645		7			2,645	26
27	TEN(10) AIRCONDITIONERS 6000 BTU & TEN(10) UNITS 8MI	2013	3,592		5			3,591	27
28	FOUR(4) UNITS OF AIRCONDITIONERS	2013	7,097		5			7,097	28
29	ARMSTRONG PUMP	2014	1,305		10	131	131	382	29
30	ELECTRIC EYE PACKAGE FOR BACK DOOR	2014	1,158		10	116	116	319	30
31	SUPERVISORY ALARM PANEL	2014	3,900		10	390	390	1,073	31
32	1HP SNGL PAHSE AIR COMPRESSOR	2014	4,350		15	290	290	677	32
33	PAINTS AROUND THE BUILDING	2014	2,593		10	259	259	583	33
34	TOTAL (lines 1 thru 33)		\$ 3,422,928	\$		\$ 126,235	\$ 126,235	\$ 2,437,920	34

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

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

1/1/16

Ending:

12/31/16

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		\$ 3,422,928	\$		\$ 126,235	\$ 126,235	\$ 2,437,920	1
2	REPAIRED FIRE SPRINKLER SYSTEM	2014	2,765		20	138	138	334	2
3	REPAIRED PASSENGER ELEVATOR	2014	3,334		20	167	167	417	3
4	ROOF IMPROVEMENT	2015	3,000		20	150	150	200	4
5	GAS FIRED STEAM BOILER	2015	57,554		20	2,878	2,878	3,597	5
6	MASONRY WORK TO 4 OPENINGS	2016	8,400		20	245	245	245	6
7	10 DUAL CATEGORY CABLED LOCATIONS	2016	3,095		20	64	64	64	7
8	FIRE SPRINKLER SYSTEM REPAIR	2016	10,344		20	216	216	216	8
9	WELDING-FIRE ESCAPE RAILING	2016	5,860		15	228	228	228	9
10	RADIATOR REPAIR & REPLACEMENT	2016	4,150		20	17	17	17	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	F/S Depreciation			65,534			(65,534)		29
30									30
31	RENTED SPACE					(5,258)	(5,258)	(10,516)	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,521,430	\$ 65,534		\$ 125,080	\$ 59,546	\$ 2,432,722	34

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

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

1/1/16

Ending:

12/31/16

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		\$ 3,521,430	\$ 65,534		\$ 125,080	\$ 59,546	\$ 2,432,722	1
2	Related Party Information								2
3	Buildings:								3
4	MADO Management Allocation	1988	63,589	2,377	35	1,817	(560)	38,153	4
5									5
6									6
7									7
8									8
9	Leasehold Improvements:								9
10	MADO Management Allocation	1995	1,475		20			1,475	10
11	MADO Management Allocation	1993	24,221		20			24,221	11
12	MADO Management Allocation	2000	3,622		20	181	181	2,992	12
13	MADO Management Allocation	2001	1,569		20	78	78	1,155	13
14	MADO Management Allocation	2002	2,468		20			2,468	14
15	MADO Management Allocation	2004	695	8	20	35	27	427	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)		\$ 3,619,069	\$ 67,919		\$ 127,191	\$ 59,272	\$ 2,503,613	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$3,619,069	\$67,919		\$127,191	\$59,272	\$2,503,613	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		\$3,619,069	\$67,919		\$127,191	\$59,272	\$2,503,613	34

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

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 3,619,069	\$ 67,919		\$ 127,191	\$ 59,272	\$ 2,503,613	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		\$ 3,619,069	\$ 67,919		\$ 127,191	\$ 59,272	\$ 2,503,613	34

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

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

1/1/16

Ending:

12/31/16

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 12G, Carried Forward		\$ 3,619,069	\$ 67,919		\$ 127,191	\$ 59,272	\$ 2,503,613	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
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,619,069	\$ 67,919		\$ 127,191	\$ 59,272	\$ 2,503,613	34

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

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

1/1/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 3,619,069	\$ 67,919		\$ 127,191	\$ 59,272	\$ 2,503,613	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,619,069	\$ 67,919		\$ 127,191	\$ 59,272	\$ 2,503,613	34

**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	\$328,152	\$6,646	\$21,230	\$14,584		\$241,100	71
72	Current Year Purchases	2,600	1,560	130	(1,430)	10	130	72
73	Fully Depreciated Assets	219,567					219,567	73
74								74
75	TOTALS	\$550,319	\$8,206	\$21,360	\$13,154		\$460,797	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 Cherokee	1998	\$24,457	\$	\$	\$	5	\$24,457	76
77		Allocated from MAD0 Management		53,385	3,715	5,048	1,333	5	40,128	77
78										78
79										79
80	TOTALS			\$77,842	\$3,715	\$5,048	\$1,333		\$64,585	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$4,269,307	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$79,840	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$153,599	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$73,759	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,028,995	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	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:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.
9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$4,171 Description: Computer \$659; Postage Meter \$304; Ice Machine \$1,478; Copier \$1,730
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☐ NO

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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.
- (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.

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	

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				26,626		26,626	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>LAB</u>	39-02					238		238	12
13	Other (specify): <u></u>									13
14	TOTAL			\$		\$	\$ 26,864		\$ 26,864	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.

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 45,766	\$	1
2	Cash-Patient Deposits	73,076		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	252,209		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,706		6
7	Other Prepaid Expenses	231		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): EX ACCT, WAGE ASSIGN	(70,384)		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 320,604	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	2,734,346		15
16	Equipment, at Historical Cost	531,740		16
17	Accumulated Depreciation (book methods)	(1,961,226)		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):	1,713,235		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,018,095	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,338,699	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 454,843	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,700		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	57,099		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37		(231)		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 525,411	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,025,646		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,025,646	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,551,057	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,787,642	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,338,699	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,757,047	1
2	Restatements (describe):		2
3	PRIOR PERIOD ADJUSTMENT	285	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,757,332	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	30,310	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)	\$ 30,310	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)	\$ 1,787,642	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

1/1/16

Ending:

12/31/16

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	\$ 6,297,312	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,297,312	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	1,994	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	90,171	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)	\$ 92,165	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	MISC INCOME	7,627	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,627	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,397,104	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,798,167	31
32	Health Care	1,927,960	32
33	General Administration	2,114,314	33
	B. Capital Expense		
34	Ownership	478,890	34
	C. Ancillary Expense		
35	Special Cost Centers	47,463	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,366,794	40
41	Income before Income Taxes (line 30 minus line 40)**	30,310	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 30,310	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 6,225,656	44
45	Private Pay - Net Inpatient Revenue	99,794	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) PRIOR PERIOD ADJ	(28,138)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,297,312	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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	3,126	3,341	\$ 130,080	\$ 38.93	1
2	Assistant Director of Nursing	1,664	1,854	65,333	35.24	2
3	Registered Nurses	1,202	1,211	36,967	30.53	3
4	Licensed Practical Nurses	19,759	20,794	520,132	25.01	4
5	CNAs & Orderlies	32,239	34,428	393,001	11.42	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,671	1,855	32,030	17.27	9
10	Activity Assistants	16,423	17,463	200,667	11.49	10
11	Social Service Workers	18,633	20,108	365,821	18.19	11
12	Dietician					12
13	Food Service Supervisor	6,175	6,850	90,128	13.16	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,872	18,569	204,004	10.99	15
16	Dishwashers	99	99	1,060	10.71	16
17	Maintenance Workers	6,236	6,485	100,242	15.46	17
18	Housekeepers	19,988	22,585	249,856	11.06	18
19	Laundry	4,237	4,734	50,375	10.64	19
20	Administrator					20
21	Assistant Administrator	2,019	2,303	52,521	22.81	21
22	Other Administrative	3,832	4,176	125,166	29.97	22
23	Office Manager					23
24	Clerical	8,085	9,023	131,718	14.60	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,654	5,015	61,510	12.27	31
32	Other Health Care(specify)					32
33	Other(specify) SECURITY	32,473	34,965	394,930	11.30	33
34	TOTAL (lines 1 - 33)	199,387	215,858	\$ 3,205,541 *	\$ 14.85	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$	1-03	35
36	Medical Director	MONTHLY	6,000	9-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	MONTHLY	1,200	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	52	2,340	11-03	44
45	Social Service Consultant			12-03	45
46	Other(specify)				46
47	Social Service Director	501	14,470	12-03	47
48					48
49	TOTAL (lines 35 - 48)	553	\$ 24,010		49

C. CONTRACT NURSES

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

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		\$ 68,234	IDPH License Fee	\$	
				Unemployment Compensation Insurance		65,726	Advertising: Employee Recruitment		
				FICA Taxes		239,700	Health Care Worker Background Check		
				Employee Health Insurance		119,413	(Indicate # of checks performed 1)	35	
				Employee Meals		35,524	Patient Background Checks	1159 13,005	
				Illinois Municipal Retirement Fund (IMRF)*			Advertising	607	
				401K		6,146	Licenses, Dues & Fees	28,458	
				MISC/TRAINING/INCENTIVES		2,415			
				UNIFORMS		518			
							MADO ALLOCATION	570	
							Less: Public Relations Expense	()	
							Non-allowable advertising	(607)	
							Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)							TOTAL (agree to Sch. V, line 20, col. 8)	\$ 42,068	
				TOTAL (agree to Schedule V, line 22, col.8)			\$ 537,676		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
MANAGEMENT FEES			\$ 718,000				Out-of-State Travel	\$	
ADMINISTRATOR-MADO			103,600						
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)									
C. Professional Services							Seminar Expense	4,520	
Vendor/Payee	Type		Amount						
PERSONNEL PLANNERS	UNEMPLOYMENT CONS		\$ 1,539				Entertainment Expense	()	
BKD, LLP	ACCOUNTING		10,827				(agree to Sch. V, line 24, col. 8)		
LIFE SAFETY RESOURCES	BLDG INSP CONSULTANT		2,266				TOTAL	\$ 4,520	
	MISC PROF FEES		2,823						
DRINKERBIDDLE & REATH	LEGAL		679						
	MISC PROF FEES (NONALLO		18,828						
	DATA PROCESSING		61,660						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				TOTAL			\$		
			\$ 98,622						

*** Attach copy of IMRF notifications**

****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			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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?
If YES, give association name and amount.

NO

(3)

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

NO

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

NO

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

YES
5-10 YRS

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.
\$
Line

950
10-02

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

YES

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

NO
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
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

X

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$
0

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

NO
- (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?
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.

YES

(15)

Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.
\$
Has any meal income been offset against related costs?
Indicate the amount. \$

35,524
N/A

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

NO

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

NO

c.

What percent of all travel expense relates to transportation of nurses and patients?

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?
Indicate the amount of income earned from providing such transportation during this reporting period.

NO
N/A

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

NO

(18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

YES

(19)

Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees

YES