

		FOR BHF USE					

LL1

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: 0023770

Facility Name: ST MARTHA MANOR

Address: 4621 N RACINE AVENUE CHICAGO 60640
Number City Zip Code

County: COOK

Telephone Number: (773) 784-2300 Fax # (773-769-4621)

HFS ID Number:

Date of Initial License for Current Owners: 12/1/1977

Type of Ownership:

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

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

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: PETER O'BRIEN Telephone Number: (312) 787-9400
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

(Signed) _____
(Type or Print Name) _____
(Title) _____

Paid
Preparer

(Signed) _____
(Print Name and Title) CAMILLE B. LOCKHART
PARTNER
(Firm Name & Address) BKD, LLP
P. O. BOX 1190, SPRINGFIELD, MO 65801-1190
(Telephone) (417) 865-8701 Fax # (417) 865-0682

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 ST MARTHA MANOR

0023770 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	<u>57</u>	Skilled (SNF)	<u>57</u>	<u>20,862</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>75</u>	Intermediate (ICF)	<u>75</u>	<u>27,450</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>132</u>	TOTALS	<u>132</u>	<u>48,312</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,660</u>	<u>9</u>		<u>1,669</u>	8
9	SNF/PED					9
10	ICF	<u>43,577</u>	<u>30</u>		<u>43,607</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>45,237</u>	<u>39</u>		<u>45,276</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.72%

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

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

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

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

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

I. On what date did you start providing long term care at this location? Date started 11/1/1978

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 11/1/1978 NO ☐

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ 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 **ST MARTHA MANOR** # **0023770** 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	223,642	31,913		255,555		255,555		255,555			1
2	Food Purchase		235,677		235,677	(28,281)	207,396	(16)	207,380			2
3	Housekeeping	145,678	54,015		199,693		199,693		199,693			3
4	Laundry	125,867	11,993		137,860		137,860		137,860			4
5	Heat and Other Utilities			146,662	146,662		146,662	1,235	147,897			5
6	Maintenance	45,754		275,155	320,909		320,909	(11,510)	309,399			6
7	Other (specify):*	99,887			99,887		99,887		99,887			7
8	TOTAL General Services	640,828	333,598	421,817	1,396,243	(28,281)	1,367,962	(10,291)	1,357,671			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	1,731,654	118,450	1,200	1,851,304		1,851,304		1,851,304			10
10a	Therapy			187	187		187		187			10a
11	Activities	179,225	11,714	2,371	193,310		193,310		193,310			11
12	Social Services	240,404		5,848	246,252		246,252		246,252			12
13	CNA Training											13
14	Program Transportation			2,079	2,079		2,079		2,079			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,151,283	130,164	12,885	2,294,332		2,294,332		2,294,332			16
	C. General Administration											
17	Administrative	46,038		589,800	635,838		635,838	(385,290)	250,548			17
18	Directors Fees											18
19	Professional Services			75,478	75,478		75,478	(2,672)	72,806			19
20	Dues, Fees, Subscriptions & Promotions			19,442	19,442		19,442	(300)	19,142			20
21	Clerical & General Office Expenses	31,506	23,729	31,098	86,333		86,333	329,582	415,915			21
22	Employee Benefits & Payroll Taxes			562,496	562,496	28,281	590,777		590,777			22
23	Inservice Training & Education			190	190		190		190			23
24	Travel and Seminar			4,622	4,622		4,622	(4,472)	150			24
25	Other Admin. Staff Transportation							1,720	1,720			25
26	Insurance-Prop.Liab.Malpractice			203,631	203,631		203,631	3,397	207,028			26
27	Other (specify):*							62,632	62,632			27
28	TOTAL General Administration	77,544	23,729	1,486,757	1,588,030	28,281	1,616,311	4,597	1,620,908			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,869,655	487,491	1,921,459	5,278,605		5,278,605	(5,694)	5,272,911			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			28,481	28,481		28,481	43,378	71,859			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			90,307	90,307		90,307	31,307	121,614			32
33	Real Estate Taxes							130,623	130,623			33
34	Rent-Facility & Grounds			186,000	186,000		186,000	(186,000)				34
35	Rent-Equipment & Vehicles			4,648	4,648		4,648		4,648			35
36	Other (specify):*											36
37	TOTAL Ownership			309,436	309,436		309,436	19,308	328,744			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		18,440		18,440		18,440		18,440			39
40	Barber and Beauty Shops			1,230	1,230		1,230		1,230			40
41	Coffee and Gift Shops		2,670		2,670		2,670	(3,470)	(800)			41
42	Provider Participation Fee			346,001	346,001		346,001		346,001			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		21,110	347,231	368,341		368,341	(3,470)	364,871			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,869,655	508,601	2,578,126	5,956,382		5,956,382	10,144	5,966,526			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	(16)	02		13
14	Non-Care Related Interest	(7,229)	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	(8,083)	21		18
19	Entertainment	(4,472)	24		19
20	Contributions	(900)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(12,315)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(778)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,931)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	15,887			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (19,837)		\$	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)	29,981		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 29,981		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 10,144		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	\$ (2,608)	21	1
2	VENDING MACHINE INCOME	(800)	41	2
3	BANK CHARGES	(1,589)	21	3
4	CIGARETTES	(2,670)	41	4
5	ADJ TO SL DEPR	38,262	30	5
6	CAPITALIZED R&M	(14,708)	6	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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	15,887		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ST MARTHA MANOR # 0023770 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	(16)	0	0	0	0	0	0	0	0	0	0	(16)	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	0	0	1,235	0	0	0	0	0	0	0	0	1,235	5
6	Maintenance	(14,708)	0	3,198	0	0	0	0	0	0	0	0	(11,510)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(14,724)	0	4,433	0	0	0	0	0	0	0	0	(10,291)	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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(385,290)	0	0	0	0	0	0	0	0	(385,290)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(12,315)	0	9,643	0	0	0	0	0	0	0	0	(2,672)	19
20	Fees, Subscriptions & Promotions	(778)	0	478	0	0	0	0	0	0	0	0	(300)	20
21	Clerical & General Office Expenses	(15,111)	0	344,693	0	0	0	0	0	0	0	0	329,582	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	(4,472)	0	0	0	0	0	0	0	0	0	0	(4,472)	24
25	Other Admin. Staff Transportation	0	0	1,720	0	0	0	0	0	0	0	0	1,720	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,397	0	0	0	0	0	0	0	0	3,397	26
27	Other (specify):*	0	0	62,632	0	0	0	0	0	0	0	0	62,632	27
28	TOTAL General Administration	(32,676)	0	37,273	0	0	0	0	0	0	0	0	4,597	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(47,400)	0	41,706	0	0	0	0	0	0	0	0	(5,694)	29

Summary B

12/31/16

[illegible]

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
PETER O'BRIEN	100	MARGARET MANOR, INC.	CHICAGO	4621 Property LLC	CHICAGO	REAL ESTATE
		MARGARET MANOR NORTH	CHICAGO	Mado Management	CHICAGO	BOOKKEEPING/M
		SACRED HEART HOME	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	\$ 186,000	4621 PROPERTY LLC	100.00%	\$	\$(186,000)	1
2	V	32	INTEREST				26,477	26,477	2
3	V	33	REAL ESTATE TAXES				125,582	125,582	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			\$ 186,000			\$ 152,059	\$ *(33,941)	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.

☒ X

 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%	\$ 1,235	\$ 1,235	15
16	V	6	Repairs & Maintenance		Mado Management	100.00%	3,198	3,198	16
17	V	19	Professional Fees		Mado Management	100.00%	9,643	9,643	17
18	V	20	Dues and Subscriptions		Mado Management	100.00%	478	478	18
19	V	21	Clerical and General		Mado Management	100.00%	344,693	344,693	19
20	V	25	Auto Expense		Mado Management	100.00%	1,720	1,720	20
21	V	26	Insurance		Mado Management	100.00%	3,397	3,397	21
22	V	27	Employee Benefits		Mado Management	100.00%	40,451	40,451	22
23	V	30	Depreciation		Mado Management	100.00%	5,116	5,116	23
24	V	32	Interest		Mado Management	100.00%	12,059	12,059	24
25	V	33	Real Estate Taxes		Mado Management	100.00%	5,041	5,041	25
26	V								26
27	V	17	Management Fees	486,000	Mado Management	100.00%		(486,000)	27
28	V								28
29	V	17	Salary - P. O'Brien		Mado Management	100.00%	61,752	61,752	29
30	V	27	Employee Benefits		Mado Management	100.00%	5,061	5,061	30
31	V								31
32	V	17	Administrative Salary		Mado Management	100.00%	38,958	38,958	32
33	V	27	Employee Benefits		Mado Management	100.00%	17,120	17,120	33
34	V								34
35	V	17	Administrative Salary	103,000	Mado Management	100.00%	103,000		35
36	V								36
37	V								37
38	V								38
39	Total			\$ 589,000			\$ 652,922	\$ * 63,922	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.

☐ 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.

☐ 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.

☐ 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.

☐ 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.

☐ 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.

☐ 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.

☐ 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

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 ST MARTHA MANOR # 0023770 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	12	19.73	ALLOC SAL	\$ 61,752	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	\$ 61,752		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 ST MARTHA MANOR # 0023770 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 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,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	Utilities	Patient Days	175,983	4	\$ 4,800	\$	45,276	\$ 1,235	1
2	6	Repair & Maintenance	Patient Days	175,983		12,430		45,276	3,198	2
3	19	Professional Fees	Patient Days	175,983		37,480		45,276	9,643	3
4	20	Dues and Subscriptions	Patient Days	175,983		1,859		45,276	478	4
5	21	Clerical and General	Patient Days	175,983		1,339,788	1,305,092	45,276	344,693	5
6	25	Auto Expense	Patient Days	175,983		6,686		45,276	1,720	6
7	26	Insurance	Patient Days	175,983		13,203		45,276	3,397	7
8	27	Employee Benefits	Patient Days	175,983		157,228		45,276	40,451	8
9	30	Depreciation	Patient Days	175,983		19,885		45,276	5,116	9
10	32	Interest	Patient Days	175,983		46,871		45,276	12,059	10
11	33	Real Estate Taxes	Patient Days	175,983		19,592		45,276	5,041	11
12										12
13	17	Salary - P. O'Brien	Avg Hrs Worked		4	240,000	240,000		61,752	13
14	27	Employee Benefits	Avg Hrs Worked		4	19,669			5,061	14
15										15
16	17	Administrative Salary	Direct Allocation			94,308	94,308		38,958	16
17	27	Employee Benefits	Direct Allocation			50,704			17,120	17
18										18
19	17	Administrative Salary	Direct Allocation			103,000	103,000		103,000	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,167,503	\$ 1,742,400		\$ 652,922	25

Facility Name & ID Number ST MARTHA MANOR # 0023770 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 ST MARTHA MANOR # 0023770 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 ST MARTHA MANOR # 0023770 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 ST MARTHA MANOR # 0023770 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 ST MARTHA MANOR # 0023770 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 ST MARTHA MANOR # 0023770 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 ST MARTHA MANOR # 0023770 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 ST MARTHA MANOR # 0023770 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 ST MARTHA MANOR # 0023770 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	BRIDGEVIEW BANK		X				\$	204,181			\$	26,477	1
2	(4621 CORP)												2
3													3
4													4
5													5
	Working Capital												
6	BRIDGEVIEW BANK		X					1,543,750				44,129	6
7	SIGNATURE BANK		X					850,686				36,962	7
8													8
9	TOTAL Facility Related						\$	2,598,617			\$	107,568	9
	B. Non-Facility Related*												
10	SEIU PENSION FUND											1,987	10
11	R/E TAX INTEREST											7,229	11
12													12
13	ALLOC FROM MADO MGT											12,059	13
14	TOTAL Non-Facility Related						\$				\$	21,275	14
15	TOTALS (line 9+line14)						\$	2,598,617			\$	128,843	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

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	132,270	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.)				\$	132,972	2
3. Under or (over) accrual (line 2 minus line 1).				\$	702	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	129,921	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.				\$	130,623	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2011	100,085	8		
		2012	111,208	9		
		2013	123,626	10		
		2014	125,972	11		
		2015	127,931	12		
Allocated from MADO Management = \$5,041				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 ST MARTHA MANOR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0023770

CONTACT PERSON REGARDING THIS REPORT PETER O'BRIEN

TELEPHONE (312) 787-9400 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 Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 14-17-207-006	Long Term Care Property	\$ 84,039.31	\$ 84,039.31
2. 14-17-207-012	Long Term Care Property	\$ 1,394.05	\$ 1,394.05
3. 14-17-207-013	Long Term Care Property	\$ 8,704.92	\$ 8,704.92
4. 14-17-207-014	4616 North Clifton (30%)	\$ 17,617.08	\$ 17,617.08
5. 14-17-207-019	Long Term Care Property	\$ 16,175.49	\$ 16,175.49
6. 17-04-204-012	Home Office	\$ 28,812.11	\$ 5,040.59
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 156,742.96	\$ 132,971.44

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 NAMEST MARTHA MANORCOUNTYCOOK

FACILITY IDPH LICENSE NUMBER0023770

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
Tax Index Number	Property Description	Total 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: 35,364

B. General Construction Type: Exterior Frame Fire Retardent

Number of Stories 4

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
NONE

E. Does this cost report reflect any organization or pre-operating costs which are being amortized?
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	12,868	1984	\$ 70,700	1
2					2
3	TOTALS	12,868		\$ 70,700	3

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1984	1975	\$ 1,494,824	\$	35	\$	\$	\$ 1,494,824	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1978	541					541	9
10	Various			1979	38,105					38,105	10
11	Various			1981	22,244					22,244	11
12	Various			1982	12,527					12,527	12
13	Various			1983	5,530					5,530	13
14	Various			1984	25,958					25,958	14
15	Various			1985	10,641					10,641	15
16	Various			1986	13,635			682	682	12,161	16
17	Various			1987	65,231					65,231	17
18	Various			1988	30,395					30,395	18
19	Various			1990	115,949					115,949	19
20	Various			1991	10,000					10,000	20
21	Various			1992	22,069					22,069	21
22	Various			1993	18,217					18,217	22
23	Various			1994	12,220					12,220	23
24	Various			1995	109,219					109,219	24
25	Various			1996	28,361			281	281	28,361	25
26	Various			1997	69,848			3,227	3,227	68,410	26
27	Various			1998	56,951			2,848	2,848	52,734	27
28	Various			1999	93,038			4,652	4,652	81,677	28
29	Various			2000	84,672			4,234	4,234	69,744	29
30	Various			2001	72,394			3,620	3,620	56,472	30
31	Various			2002	121,688					121,688	31
32	Various			2003	57,379			2,869	2,869	38,723	32
33	Various			2004	89,609			6,741	6,741	96,350	33
34	Various			2005	31,058			2,520	2,520	29,049	34
35	Various			2006	23,468			2,106	2,106	21,971	35
36	Various			2007	10,166			508	508	4,755	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number ST MARTHA MANOR

0023770

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	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	2008	\$ 18,781	\$	20	\$ 939	\$ 939	\$ 8,096	37
38 Replace Fire Doors	2009	3,772		20	189	189	1,400	38
39 Electrical Work In The Courtyard	2009	7,185		20	359	359	2,723	39
40 Electric Lock For Pedestrian Gate	2009	2,584		20	129	129	979	40
41 Brick Patio & Retaining Wall	2009	4,100		20	205	205	1,555	41
42 Repairs To Air Conditioning System	2009	2,685		20	134	134	984	42
43 Condensing Motor Fan	2009	4,433		20	222	222	1,664	43
44 Fire Alarm Wiring	2009	3,453		20	173	173	1,354	44
45 Therapy - Whirlpool Tub	2010	8,437		20	422	422	2,637	45
46 Furnish & Install Water Heater	2010	9,735		20	487	487	3,408	46
47 Sprinkler Heads	2010	4,769		20	238	238	1,588	47
48 Electrical Work - Elevator	2010	16,786		20	839	839	5,524	48
49 Electrical Work	2010	9,935		20	497	497	3,188	49
50 Cold Water Pressure Pump	2011	3,785		20	189	189	1,008	50
51 Fire Escape Improvement Per Idph Requirement	2011	17,595		20	880	880	5,206	51
52 Replaced Burned Wire, Filters For Two Compressors	2011	3,665		20	183	183	1,022	52
53 20 Ton Semi-Hermetic Reciprocating Compressor	2012	13,730		20	687	687	2,977	53
54 Bathroom Renovation (Ceiling, Electrical, Plumbing, Drywall, Flo	2012	8,570		20	429	429	1,752	54
55 Install New Dampers	2012	3,370		20	169	169	690	55
56 Sealed Wall Cracks; Rebuilt Damage Part Wall	2012	3,850		20	193	193	965	56
57 Installed New Valve And Drained Line	2012	4,654		20	233	233	1,165	57
58 Fire Sprinkler Repairs	2012	5,859		20	293	293	1,465	58
59 Fire Alarm Repairs	2012	3,762		20	188	188	940	59
60 Furnished And Installed Heating Elements For Water Heater Boo	2012	2,663		20	133	133	665	60
61 Replaced Armaflex Insulation	2012	3,546		20	177	177	885	61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 2,917,641	\$		\$ 42,875	\$ 42,875	\$ 2,729,603	70

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

Facility Name & ID Number ST MARTHA MANOR

0023770

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,917,641	\$		\$ 42,875	\$ 42,875	\$ 2,729,603	1
2									2
3	Bathrooms-2nd-4th floor north - drywall, floors, fixtures, painting	2013	31,539		20	1,577	1,577	4,765	3
4	Asphalt Resurface	2013	12,500		8	1,563	1,563	5,080	4
5	Repaired South Passenger Elevator	2013	4,021		20	201	201	737	5
6	Repaired Mop Sink	2013	2,500		20	125	125	385	6
7	Install New 50 HP 230 Volt Pump Motor	2013	3,039		15	203	203	626	7
8	Excavated 25 Feet for Washing machine Line	2013	4,300		25	172	172	573	8
9	Repaired Fire Alarm System	2013	2,509		10	251	251	1,004	9
10	Tamper Panel Fire Detection System	2014	15,800		10	1,580	1,580	4,740	10
11	Steam Boiler	2014	34,860		20	1,743	1,743	4,793	11
12	Steam Compressor	2014	19,670		20	984	984	2,542	12
13	Bathrooms-2nd-5th floor south - materials and labor to replace	2014	65,876		20	3,294	3,294	6,863	13
14	walls, ceilings, floors, electrical & plumbing, fixtures; painting								14
15	Elevator repair-Hydraulic valve	2014	2,991		20	150	150	313	15
16	Elevator repair-Upgrades	2015	15,740		20	787	787	1,574	16
17	Elevator repair-Upgrades	2015	47,600		20	2,380	2,380	4,363	17
18	1st floor bathroom materials-electrical, floors, fixtures, drywall, pa	2015	2,713		20	136	136	147	18
19	Warehouse, laundry, 1st flr bthrm materials-electrical, floors, fixt	2015	3,398		20	170	170	170	19
20	Repaired hydraulic pistons - south elevator	2015	3,095		20	155	155	207	20
21	#1 & 2 Elevators-Wiring. Furnish & install 2 emergency telephone	2015	2,561		20	128	128	149	21
22	Kitchen Ventilation Fan	2016	3,000		20	125	125	125	22
23	Elevator-Replace car sill, new gibs and hangers	2016	2,969		20	136	136	136	23
24	Elevator-Replace Hydraulic valve & oil	2016	4,419		20	184	184	184	24
25	Elevator-Repairs to North & South	2016	7,320		20	31	31	31	25
26									26
27									27
28									28
29									29
30									30
31	F/S Depreciation			25,901			(25,901)		31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,210,061	\$ 25,901		\$ 58,950	\$ 33,049	\$ 2,769,109	34

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

Facility Name & ID Number ST MARTHA MANOR

0023770

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 12B, Carried Forward		\$ 3,210,061	\$ 25,901		\$ 58,950	\$ 33,049	\$ 2,769,109	1
2	Related Party								2
3	Buildings								3
4	Allocated from Mado Management	1988	53,326	1,993	35	1,524	(469)	31,996	4
5	Direct Allocation from Mado	1985	21,630		35	618	618	12,978	5
6	Direct Allocation from Mado	2009	6,540		35	187	187	1,318	6
7									7
8	Leasehold Improvements								8
9	Allocated from Mado Management	1995	1,237		20			1,237	9
10	Allocated from Mado Management	1993	20,312		20			20,312	10
11	Allocated from Mado Management	2000	3,038		20	152	152	2,509	11
12	Allocated from Mado Management	2001	1,316		20	66	66	969	12
13	Allocated from Mado Management	2002	2,070		20			2,070	13
14	Allocated from Mado Management	2004	583	7	20	29	22	358	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,320,113	\$ 27,901		\$ 61,526	\$ 33,625	\$ 2,842,855	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 12C, Carried Forward		\$ 3,320,113	\$ 27,901		\$ 61,526	\$ 33,625	\$ 2,842,855	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)		\$ 3,320,113	\$ 27,901		\$ 61,526	\$ 33,625	\$ 2,842,855	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 12D, Carried Forward		\$ 3,320,113	\$ 27,901		\$ 61,526	\$ 33,625	\$ 2,842,855	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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19									19
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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)		\$ 3,320,113	\$ 27,901		\$ 61,526	\$ 33,625	\$ 2,842,855	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		\$ 3,320,113	\$ 27,901		\$ 61,526	\$ 33,625	\$ 2,842,855	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,320,113	\$ 27,901		\$ 61,526	\$ 33,625	\$ 2,842,855	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 12F, Carried Forward		\$3,320,113	\$27,901		\$61,526	\$33,625	\$2,842,855	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$3,320,113	\$27,901		\$61,526	\$33,625	\$2,842,855	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 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		\$ 3,320,113	\$ 27,901		\$ 61,526	\$ 33,625	\$ 2,842,855	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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21									21
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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)		\$ 3,320,113	\$ 27,901		\$ 61,526	\$ 33,625	\$ 2,842,855	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 12H, Carried Forward		\$ 3,320,113	\$ 27,901		\$ 61,526	\$ 33,625	\$ 2,842,855	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)		\$ 3,320,113	\$ 27,901		\$ 61,526	\$ 33,625	\$ 2,842,855	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	\$125,142	\$2,580	\$6,100	\$3,520	Various	\$99,544	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	251,747						73
74								74
75	TOTALS	\$376,889	\$2,580	\$6,100	\$3,520		\$99,544	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		Allocated from MADO Mgt	2010	\$44,770	\$3,116	\$4,233	\$1,117	5	\$33,652	76
77										77
78										78
79										79
80	TOTALS			\$44,770	\$3,116	\$4,233	\$1,117		\$33,652	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$3,812,472	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$33,597	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$71,859	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$38,262	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,976,051	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? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 4,648 Description: Computer \$659; Ice Machine \$1,177; Copiers \$2,812
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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				18,440		18,440	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$ 18,440		\$ 18,440	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 22,785	\$	1
2	Cash-Patient Deposits	13,888		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	406,530		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,136		6
7	Other Prepaid Expenses	11,814		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Refund, Ex Acct</u>	(20,965)		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 449,188	\$	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	1,022,005		15
16	Equipment, at Historical Cost	348,666		16
17	Accumulated Depreciation (book methods)	(950,749)		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):	2,512,323		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,932,245	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,381,433	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 616,352	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,990		28
29	Short-Term Notes Payable	2,394,436		29
30	Accrued Salaries Payable	53,452		30
31	Accrued Taxes Payable (excluding real estate taxes)	(21,406)		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		1,675,978		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,720,802	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,720,802	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,339,369)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,381,433	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,105,079)	1
2	Restatements (describe):		2
3	PRIOR PERIOD ADJUSTMENT	700	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,104,379)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(234,990)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (234,990)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,339,369)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number ST MARTHA MANOR

0023770

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	\$ 5,720,006	1
2	Discounts and Allowances for all Levels	(2,022)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,717,984	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	800	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		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)	\$ 800	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	2,608	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,608	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,721,392	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,396,243	31
32	Health Care	2,294,332	32
33	General Administration	1,588,030	33
	B. Capital Expense		
34	Ownership	309,436	34
	C. Ancillary Expense		
35	Special Cost Centers	22,340	35
36	Provider Participation Fee	346,001	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,956,382	40
41	Income before Income Taxes (line 30 minus line 40)**	(234,990)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (234,990)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 5,719,879	44
45	Private Pay - Net Inpatient Revenue	127	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify) PRIOR YR ADJ	(2,022)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,717,984	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	1,896	2,040	\$ 71,012	\$ 34.81	1
2	Assistant Director of Nursing	1,608	1,817	58,268	32.07	2
3	Registered Nurses	6,600	7,224	204,536	28.31	3
4	Licensed Practical Nurses	27,260	29,236	714,190	24.43	4
5	CNAs & Orderlies	54,560	59,246	675,777	11.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,867	1,990	26,150	13.14	9
10	Activity Assistants	13,645	14,666	153,075	10.44	10
11	Social Service Workers	17,121	18,686	240,404	12.87	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	8,128	8,381	95,267	11.37	14
15	Cook Helpers/Assistants	11,586	12,033	128,375	10.67	15
16	Dishwashers					16
17	Maintenance Workers	4,112	4,380	45,754	10.45	17
18	Housekeepers	13,119	14,074	145,678	10.35	18
19	Laundry	11,421	12,073	125,867	10.43	19
20	Administrator					20
21	Assistant Administrator	1,803	2,056	46,038	22.39	21
22	Other Administrative					22
23	Office Manager	1,812	2,100	31,506	15.00	23
24	Clerical					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	579	716	7,871	10.99	31
32	Other Health Care(specify)					32
33	Other(specify) SECURITY	8,303	9,003	99,887	11.09	33
34	TOTAL (lines 1 - 33)	185,420	199,721	\$ 2,869,655 *	\$ 14.37	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	MONTHLY	1,200	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			10a-03	40
41	Occupational Therapy Consultant	3	187	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	64	2,371	11-03	44
45	Social Service Consultant	86	5,848	12-03	45
46	Other(specify) MAINT	7,801	115,455	6-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	7,954	\$ 126,261		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

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

** See instructions.

Facility Name & ID Number		ST MARTHA MANOR		STATE OF ILLINOIS		# 0023770		Report Period Beginning:		1/1/16		Page 21		Ending:		12/31/16	
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		\$ 63,010		IDPH License Fee		\$			
								Unemployment Compensation Insurance		28,110		Advertising: Employee Recruitment					
								FICA Taxes		215,805		Health Care Worker Background Check					
								Employee Health Insurance		192,254		(Indicate # of checks performed)					
								Employee Meals		28,281		Patient Background Checks		65 1,375			
								Illinois Municipal Retirement Fund (IMRF)*				Advertising		778			
								401K		19,782		Licenses, Dues & Fees		17,289			
								PENSION		42,683							
								UNIFORMS		(500)							
								MISC/TRAINING/GIFTS		1,352		MADO ALLOCATION		478			
												Less: Public Relations Expense		()			
												Non-allowable advertising		(778)			
												Yellow page advertising		()			
TOTAL (agree to Schedule V, line 17, col. 1)						\$		TOTAL (agree to Schedule V, line 22, col.8)		\$ 590,777		TOTAL (agree to Sch. V, line 20, col. 8)		\$ 19,142			
(List each licensed administrator separately.)																	
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		\$ 486,000						\$		Out-of-State Travel		\$					
ADMINISTRATOR-MADO		103,000															
TOTAL (agree to Schedule V, line 17, col. 3)		\$ 589,000								In-State Travel							
(Attach a copy of any management service agreement)																	
C. Professional Services																	
Vendor/Payee		Type		Amount													
PERSONAL PLANNERS		UNEMPLOY CONSULTING		\$ 1,314													
BKD, LLP		ACCOUNTING		9,897													
MARCUM LLP		ACCOUNTING		6,739													
DRINKER BIDDLE & REATH		LEGAL		2,501													
		MISC PROF FEES (NONALLO		12,315													
		DATA PROCESSING		42,712													
TOTAL (agree to Schedule V, line 19, column 3)								TOTAL		\$		Entertainment Expense		()			
(For legal fee disclosure, see page 39 of instructions)												(agree to Sch. V, line 24, col. 8)					
												TOTAL		\$ 150			

* 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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number ST MARTHA MANOR	STATE OF ILLINOIS # 0023770	Report Period Beginning: 1/1/16	Ending: 12/31/16
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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? YES

(2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. NO

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 16,420 Line 10-02

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

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 346,001
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 28,281 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____

(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 c. What percent of all travel expense relates to transportation of nurses and patients? _____
 d. Have vehicle usage logs been maintained? NO
 e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____

(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. YES
Attach invoices and a summary of services for all architect and appraisal fees