

		FOR BHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

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 Facility ID Number: 0013334

Facility Name: Sacred Heart Home

Address: 1550 South Albany Chicago 60623
 Number City Zip Code

County: Cook

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

HFS ID Number: 362707014001

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

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) _____	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Jeffrey K. Singer, C.P.A.</u>	
	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	

MAIL TO: BUREAU OF HEALTH FINANCE
 ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home

0013334 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>172</u>	Skilled (SNF)	<u>172</u>	<u>62,780</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>172</u>	TOTALS	<u>172</u>	<u>62,780</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>56,824</u>			<u>56,824</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>56,824</u>			<u>56,824</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.51%

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 07/01/1971

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ 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 _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/05 Fiscal Year: 12/31/05

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

Facility Name & ID Number Sacred Heart Home # 0013334 Report Period Beginning: 01/01/05 Ending: 12/31/05

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 OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	259,573	22,345	39,708	321,626		321,626		321,626			1
2	Food Purchase		404,554		404,554	(41,205)	363,349		363,349			2
3	Housekeeping	331,610	46,652	5,776	384,038		384,038		384,038			3
4	Laundry	13,977	25,607		39,584		39,584		39,584			4
5	Heat and Other Utilities			147,116	147,116		147,116	1,567	148,683			5
6	Maintenance	147,128		168,531	315,659		315,659	(26,149)	289,510			6
7	Other (specify):*											7
8	TOTAL General Services	752,288	499,158	361,131	1,612,577	(41,205)	1,571,372	(24,582)	1,546,790			8
	B. Health Care and Programs											
9	Medical Director			4,000	4,000		4,000		4,000			9
10	Nursing and Medical Records	766,661	38,187	640,141	1,444,989		1,444,989		1,444,989			10
10a	Therapy			761	761		761		761			10a
11	Activities	144,777	18,026	6,262	169,065		169,065		169,065			11
12	Social Services	49,336		169,295	218,631		218,631		218,631			12
13	CNA Training											13
14	Program Transportation			276	276		276		276			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	960,774	56,213	820,735	1,837,722		1,837,722		1,837,722			16
	C. General Administration											
17	Administrative			618,000	618,000		618,000	(364,324)	253,676			17
18	Directors Fees											18
19	Professional Services			93,652	93,652		93,652	2,873	96,525			19
20	Dues, Fees, Subscriptions & Promotions			28,586	28,586		28,586	(87)	28,499			20
21	Clerical & General Office Expenses	18,793	23,935	84,564	127,292		127,292	122,520	249,812			21
22	Employee Benefits & Payroll Taxes			204,810	204,810	41,205	246,015		246,015			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,323	1,323		1,323	129	1,452			24
25	Other Admin. Staff Transportation							4,817	4,817			25
26	Insurance-Prop.Liab.Malpractice			142,807	142,807		142,807	4,440	147,247			26
27	Other (specify):*							48,642	48,642			27
28	TOTAL General Administration	18,793	23,935	1,173,742	1,216,470	41,205	1,257,675	(180,990)	1,076,685			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,731,855	579,306	2,355,608	4,666,769		4,666,769	(205,572)	4,461,197			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sacred Heart Home #0013334 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			54,137	54,137	54,137	60,030	114,167				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						32,761	32,761				32
33	Real Estate Taxes						10,338	10,338				33
34	Rent-Facility & Grounds			188,400	188,400	188,400	(188,400)					34
35	Rent-Equipment & Vehicles			7,200	7,200	7,200		7,200				35
36	Other (specify):*											36
37	TOTAL Ownership			249,737	249,737	249,737	(85,271)	164,466				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			3,393	3,393	3,393		3,393				40
41	Coffee and Gift Shops		136,519		136,519	136,519	(84,058)	52,461				41
42	Provider Participation Fee			94,170	94,170	94,170		94,170				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		136,519	97,563	234,082	234,082	(84,058)	150,024				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,731,855	715,825	2,702,908	5,150,588	5,150,588	(374,901)	4,775,687				45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning: 01/01/05

Ending: 12/31/05

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	53,716	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(296)	21		18
19	Entertainment				19
20	Contributions	(200)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(717)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(478)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(132,972)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (80,947)		\$	30

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	2	
		Amount	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)	(293,954)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (293,954)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (374,901)		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	2	3	4	
		Yes	No	Amount	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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

OHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
1 PPA - REM	\$ (680)	06	1
2 PPA - Insurance	(1,510)	28	2
3 Capitalized REM	(28,392)	06	3
4 Vending	(84,058)	41	4
5 Bank Charges	(16,342)	21	5
6 Annual Report	(100)	20	6
7 Prior Year Legal	(1,890)	19	7
8			8
9			9
10			10
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96			96
97			97
98			98
99			99
100			100
101 Total	(132,972)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/05

Ending:

12/31/05

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase													2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,567									1,567	5
6	Maintenance	(29,072)		2,923									(26,149)	6
7	Other (specify):*													7
8	TOTAL General Services	(29,072)		4,490									(24,582)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative		90,000	(592,477)	80,724	57,429							(364,324)	17
18	Directors Fees													18
19	Professional Services	(1,890)		4,763									2,873	19
20	Fees, Subscriptions & Promotions	(1,017)		930									(87)	20
21	Clerical & General Office Expenses	(17,116)		114,636		25,000							122,520	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			129									129	24
25	Other Admin. Staff Transportation			4,817									4,817	25
26	Insurance-Prop.Liab.Malpractice	(1,510)		5,950									4,440	26
27	Other (specify):*			29,136	10,897	8,609							48,642	27
28	TOTAL General Administration	(21,533)	90,000	(432,116)	91,621	91,038							(180,990)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(50,605)	90,000	(427,626)	91,621	91,038							(205,572)	29

STATE OF ILLINOIS

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/05 Ending:

Summary B

12/31/05

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	53,716		6,314									60,030	30
31	Amortization of Pre-Op. & Org.													31
32	Interest			32,761									32,761	32
33	Real Estate Taxes		7,074	3,264									10,338	33
34	Rent-Facility & Grounds		(188,400)										(188,400)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	53,716	(181,326)	42,339									(85,271)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops	(84,058)											(84,058)	41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	(84,058)											(84,058)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(80,947)	(91,326)	(385,287)	91,621	91,038							(374,901)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Peter O' Brien	60.00%	See Attached		See Attached		
Daniel O'Brien	20.00%					
Mary O'Brien	20.00%					

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 188,400	Long Term Care LP		\$	(188,400)	1
2	V	33 Real Estate Taxes		Long Term Care LP		7,074	7,074	2
3	V	17 Management Fees		Long Term Care LP		90,000	90,000	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		\$ 188,400			\$ 97,074	\$ * (91,326)	14

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

Facility Name & ID Number Sacred Heart Home # 0013334 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5 UTILITIES	\$	MADO MGMT. LP	100.00%	\$ 1,567	\$ 1,567	15
16	V	6 REPAIRS AND MAINT.				2,923	2,923	16
17	V	17 ADMINISTRATIVE				25,523	25,523	17
18	V	19 PROFESSIONAL FEES				4,763	4,763	18
19	V	20 DUES AND SUBSCRIPTIONS				930	930	19
20	V	21 CLERICAL AND GENERAL				114,636	114,636	20
21	V	24 SEMINARS				129	129	21
22	V	25 AUTO EXPENSE				4,817	4,817	22
23	V	26 PROPERTY INSURANCE				5,950	5,950	23
24	V	27 GEN. ADMIN. - EMP. BEN.				29,136	29,136	24
25	V	30 DEPRECIATION				6,314	6,314	25
26	V	32 INTEREST				32,761	32,761	26
27	V	33 REAL ESTATE TAXES				3,264	3,264	27
28	V							28
29	V	17 MANAGEMENT FEES	618,000				(618,000)	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		\$ 618,000			\$ 232,713	\$ * (385,287)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	SALARY-D. O'BRIEN	\$	MADO MGMT. LP	100.00%	\$ 40,362	\$ 40,362	15
16	V	27	EMP. BEN.-D. O'BRIEN				4,781	4,781	16
17	V								17
18	V	17	SALARY-P. O'BRIEN				40,362	40,362	18
19	V	27	EMP. BEN.-P. O'BRIEN				6,116	6,116	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
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34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 91,621	\$ * 91,621	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	17 ADMINISTRATIVE SALARY		MADO MGMT. LP		57,429	57,429	19
20	V	21 CLERICAL SALARY				25,000	25,000	20
21	V	27 GEN. ADMIN. - EMP. BEN.				8,609	8,609	21
22	V	30 DEPRECIATION-WAREHOUSE						22
23	V	33 REAL ESTATE TAXES						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		\$			\$ 91,038	\$ * 91,038	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	21	Office	\$ 69,562	Windy City Nursing	100.00%	\$ 69,562		15
16	V	01	Dietary	28,178	Windy City Nursing	100.00%	28,178		16
17	V	12	Social Services	162,780	Windy City Nursing	100.00%	162,780		17
18	V	10	Nursing	407,019	Windy City Nursing	100.00%	407,019		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		\$ 667,539				\$ 667,539	\$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing Supplies	\$ 7,371	St. Agnes Medical Supplies	100.00%	\$ 7,371	\$	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			\$ 7,371			\$ 7,371	\$ *	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			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

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

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

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

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

Facility Name & ID Number Sacred Heart Home # 0013334 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	Daniel O'Brien	Owner	Administrative	20.00%	See Attached	5.70	14.25%	Alloc Sal	\$ 40,362	17-07	1
2	Peter O'Brien	Owner	Administrative	60.00%	See Attached	10.90	18.17%	Alloc Sal	40,362	17-07	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 80,724		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home

0013334 Report Period Beginning: 01/01/05 Ending: 12/31/05

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning: 01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization MADO MGMT. LP
 Street Address 1541 N. WELLS ST.
 City / State / Zip Code CHICAGO, IL. 60610
 Phone Number (312) 787-9400
 Fax Number (312) 787-9434

1	2	3	4	5	6	7	8	9	
Schedule V 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	5	UTILITIES	PATIENT DAYS	239,337	5	\$ 6,600	\$ 56,824	\$ 1,567	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	239,337	5	12,313	56,824	2,923	2
3	17	ADMINISTRATIVE	PATIENT DAYS	239,337	5	107,500	107,500	56,824	25,523
4	19	PROFESSIONAL FEES	PATIENT DAYS	239,337	5	20,060	56,824	4,763	4
5	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	239,337	5	3,917	56,824	930	5
6	21	CLERICAL AND GENERAL	PATIENT DAYS	239,337	5	482,833	418,211	56,824	114,636
7	24	SEMINARS	PATIENT DAYS	239,337	5	544	56,824	129	7
8	25	AUTO EXPENSE	PATIENT DAYS	239,337	5	20,290	56,824	4,817	8
9	26	PROPERTY INSURANCE	PATIENT DAYS	239,337	5	25,061	56,824	5,950	9
10	27	GEN. ADMIN. - EMP. BEN.	PATIENT DAYS	239,337	5	122,717	56,824	29,136	10
11	30	DEPRECIATION	PATIENT DAYS	239,337	5	26,595	56,824	6,314	11
12	32	INTEREST	PATIENT DAYS	239,337	5	137,986	56,824	32,761	12
13	33	REAL ESTATE TAXES	PATIENT DAYS	239,337	5	13,749	56,824	3,264	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					\$ 980,165	\$ 525,711	\$ 232,713	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning: 01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization MADO MGMT. LP
 Street Address 1541 N. WELLS ST.
 City / State / Zip Code CHICAGO, IL. 60610
 Phone Number (312) 787-9400
 Fax Number (312) 787-9434

1	2	3	4	5	6	7	8	9	
Schedule V 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	17	SALARY-D. O'BRIEN	AVG. HOURS WORKED 24	5	170,000	170,000	6	40,362	1
2	27	EMP. BEN.-D. O'BRIEN	AVG. HOURS WORKED 24	5	20,137		6	4,781	2
3									3
4	17	SALARY-P. O'BRIEN	AVG. HOURS WORKED 46	5	170,000	170,000	11	40,362	4
5	27	EMP. BEN.-P. O'BRIEN	AVG. HOURS WORKED 46	5	25,761		11	6,116	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				\$ 385,898	\$ 340,000		\$ 91,621	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home

0013334 Report Period Beginning: 01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization MADO MGMT. LP
 Street Address 1541 N. WELLS ST.
 City / State / Zip Code CHICAGO, IL. 60610
 Phone Number (312) 787-9400
 Fax Number (312) 787-9434

1	2	3	4	5	6	7	8	9	
Schedule V 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	17	ADMINISTRATIVE SALARY	DIRECT ALLOCATION	5	272,875	272,875		57,429	5
6	21	CLERICAL SALARY	DIRECT ALLOCATION	2	52,600	52,600		25,000	6
7	27	GEN. ADMIN. - EMP. BEN.	DIRECT ALLOCATION	5	64,126			8,609	7
8	30	DEPRECIATION-WAREHOUSE	DIRECT ALLOCATION	1	216				8
9	33	REAL ESTATE TAXES	DIRECT ALLOCATION	1	2,230				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				\$ 392,047	\$ 325,475		\$ 91,038	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning: 01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Windy City Nursing
 Street Address 1541 N. Wells St.
 City / State / Zip Code Chicago, IL 60610
 Phone Number (312) 787-9400
 Fax Number (312) 787-9434

1	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	21	Office			\$	\$		\$ 69,562	1
2	1	Dietary						28,178	2
3	12	Social Services						162,780	3
4	10	Nursing						407,019	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				\$	\$		\$ 667,539	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/05

Ending: 12/31/05

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 St. Agnes Medical Supply
 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 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	10	Nursing Supplies	Direct Allocation		\$	\$		\$ 7,371	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				\$	\$		\$ 7,371	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home

0013334 Report Period Beginning: 01/01/05 Ending: 12/31/05

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home

0013334 Report Period Beginning: 01/01/05 Ending: 12/31/05

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home

0013334 Report Period Beginning: 01/01/05 Ending: 12/31/05

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/05

Ending: 12/31/05

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

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5	See Supplemental Schedule																			
Working Capital																				
6	Allocate MADDO Mgmt		X							32,761	6									
7										7										
8	See Supplemental Schedule																			
9	TOTAL Facility Related									32,761	9									
B. Non-Facility Related*																				
10										10										
11										11										
12										12										
13	See Supplemental Schedule																			
14	TOTAL Non-Facility Related										14									
15	TOTALS (line 9+line14)									32,761	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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

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

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

** 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

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2004 report.		\$ 3,362	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.)		\$ 6,160	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 2,798	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 7,540	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.		\$ 10,338	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2000	3,101	8
	2001	3,181	9
	2002	3,217	10
	2003	2,833	11
	2004	2,896	12
<u>2005 Accrual - \$2,896 X 1.19 = \$3,437</u>			
<u>MADO Management Allocation - \$3,264</u>			

	FOR OHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2004 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sacred Heart Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0013334

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>16-24-106-035-0000</u>	<u>Long Term Care Property</u>	\$ <u>372.22</u>	\$ <u>372.22</u>
2. <u>16-24-106-036-0000</u>	<u>Long Term Care Property</u>	\$ <u>729.48</u>	\$ <u>729.48</u>
3. <u>16-24-106-037-0000</u>	<u>Long Term Care Property</u>	\$ <u>1,794.64</u>	\$ <u>1,794.64</u>
4. <u>See Attached</u>	<u>Home Office Allocation</u>	\$ <u>20,219.09</u>	\$ <u>3,264.32</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>23,115.43</u>	\$ <u>6,160.66</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 & 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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 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 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sacred Heart Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0013334

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 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 2004.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

Facility Name & ID Number Sacred Heart Home# 0013334 Report Period Beginning:01/01/05 Ending:12/31/05**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 79,940 B. General Construction Type: Exterior Frame Number of Stories 3C. 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).

NoneF. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>			\$ <u>22,077</u>	1
2					2
3	TOTALS			\$ <u>22,077</u>	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Various			1973	9,000		20			9,000	9
10	Various			1975	16,880		20			16,880	10
11	Various			1976	4,234		20			4,234	11
12	Various			1977	43,234		20			43,234	12
13	Various			1978	50,867		20			50,867	13
14	Various			1979	40,393		20			40,393	14
15	Various			1980	4,392		20			4,392	15
16	Various			1981	15,817		20			15,817	16
17	Various			1982	15,180		20			15,180	17
18	Various			1984	7,505		20			7,505	18
19	Various			1985	60,377		20			60,377	19
20	Various			1986	41,792		20			41,792	20
21	Various			1987	17,344		20			17,344	21
22	Various			1988	13,840		20			13,824	22
23	Various			1989	10,568		20			10,568	23
24	Various			1990	48,324		20	2	2	48,324	24
25	Various			1991	26,113		20	132	132	25,258	25
26	Various			1992	105,671		20	5,284	5,284	99,361	26
27	Various			1993	14,487		20			14,487	27
28	Various			1994	37,950		20	1,898	1,898	22,774	28
29	Various			1995	38,705		20	1,935	1,935	19,351	29
30	Various			1996	34,431		20	1,721	1,721	17,543	30
31	Various			1997	62,792		20	3,143	3,143	26,554	31
32	Various			1998	73,236		20	3,664	3,664	28,404	32
33	Various			1999	51,272		20	2,563	2,563	16,594	33
34	Various			2000	120,486		20	6,028	6,028	33,875	34
35	Various			2001	159,720		20	7,992	7,992	35,589	35
36											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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		140,000					140,000	67
68		75,563	2,560		2,794	234	28,044	68
69			34,944			(34,944)		69
70		\$ 1,340,173	\$ 37,504		\$ 37,156	\$ (348)	\$ 907,565	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sacred Heart Home

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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		\$ 1,340,173	\$ 37,504		\$ 37,156	\$ (348)	\$ 907,565	1
2	Indoor Security Camera	2002	5,354		20	765	765	2,613	2
3	Ceiling Supplies	2002	552		20	55	55	221	3
4	Vertical Blinds	2002	2,610		20	261	261	1,044	4
5	Door Repairs/Smoke Stack	2002	800		20	80	80	313	5
6	Shower Plumbing	2002	4,690		20	469	469	1,798	6
7	Door Supplies	2002	1,040		20	104	104	381	7
8	Power Hide-Walls	2002	1,270		20	127	127	466	8
9	Gutter/Roof Repairs	2002	2,500		20	250	250	917	9
10	Gutter/Down Spouts/Roof Repairs	2002	2,000		20	200	200	733	10
11	Gutter/Down Spouts/Roof Repairs	2002	2,700		20	270	270	990	11
12	Clearcoat-Floors	2002	548		20	55	55	201	12
13	Removal/Installation Of Walls	2002	3,319		20	332	332	1,217	13
14	Vertical Blinds	2002	1,351		20	135	135	507	14
15	Door & Frames	2002	2,989		20	299	299	1,096	15
16	Door & Frames	2002	2,300		20	230	230	843	16
17	Door & Frames	2002	791		20	79	79	290	17
18	Gutter/Down Spouts/Roof Repairs	2002	4,700		20	470	470	1,723	18
19	Gutter/Down Spouts/Roof Repairs	2002	2,000		20	200	200	733	19
20	Gutter/Down Spouts/Roof Repairs	2002	1,500		20	150	150	550	20
21	Gate And Fence	2002	1,234		20	123	123	452	21
22	Gate And Fence	2002	685		20	69	69	251	22
23	Generator And Remote Panel	2002	19,825		20	1,983	1,983	6,939	23
24	Base Paint	2002	880		20			880	24
25	Closet Repairs	2002	968		20	97	97	347	25
26	Concrete And Tile Removal	2002	1,890		20	189	189	677	26
27	Door Alarms	2002	513		20	73	73	244	27
28	Landscaping	2002	2,481		20	165	165	538	28
29	Door Closer	2002	557		20	56	56	181	29
30	Elevator Painting	2002	1,959		20	196	196	767	30
31	Fence Repairs	2002	750		20	75	75	244	31
32	Fire Escape Repairs	2002	8,543		20	854	854	2,776	32
33	Gate Installation	2002	2,335		20	234	234	720	33
34	TOTAL (lines 1 thru 33)		\$ 1,425,807	\$ 37,504		\$ 45,801	\$ 8,297	\$ 939,217	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sacred Heart Home

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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		\$ 1,425,807	\$ 37,504		\$ 45,801	\$ 8,297	\$ 939,217	1
2	Gate/Fence Repairs	2002	865		20	87	87	281	2
3	Hallway And Ceiling Repairs	2002	1,597		20	160	160	492	3
4	Lighting Repairs	2002	504		20	50	50	172	4
5	Painting Fire Escape	2002	3,136		20	314	314	1,098	5
6	Painting Frames And Steps	2002	1,312		20	131	131	448	6
7	Painting Supplies	2002	3,944		20	394	394	1,249	7
8	Parking Lot Repairs	2002	863		20	58	58	211	8
9	Pipe Repairs	2002	704		20	70	70	229	9
10	Renovation Of Storage Floor	2002	1,243		20	124	124	425	10
11	Replacement Of Hallway Tiles	2002	2,953		20	295	295	960	11
12	Roof Repairs	2002	11,473		20	1,147	1,147	3,633	12
13	Shower Base	2002	1,608		20	161	161	590	13
14	Shower Repairs	2002	900		20	90	90	345	14
15	Shower Stall Installation	2002	990		20	99	99	388	15
16	Sprinkler And Pipe Repairs	2002	3,835		20	384	384	1,374	16
17	Sprinkler And Repairs	2002	6,430		20	643	643	2,143	17
18	Thermostat	2002	755		20	76	76	283	18
19	Thermostat	2002	551		20	55	55	188	19
20	Tuckpointing	2002	13,900		20	1,390	1,390	4,749	20
21	Vent Repairs	2002	545		20	55	55	213	21
22	Vertical Blinds	2002	870		20	87	87	297	22
23	Wallpaper	2002	2,834		20			2,834	23
24	Welding Repairs	2002	869		20	87	87	311	24
25	Radiator Repairs	2003	2,129		20	213	213	639	25
26	Painting	2003	580		20	58	58	174	26
27	Hallway Repairs	2003	667		20	67	67	200	27
28	Fence Painting Supplies	2003	1,156		20	116	116	347	28
29	Bathroom/Shower Repairs	2003	2,325		20	233	233	698	29
30	Painting	2003	1,014		20	101	101	296	30
31	Stem Trap Installation	2003	1,389		20	139	139	405	31
32	Pump Installation	2003	2,187		20	219	219	620	32
33	Valve Repairs	2003	1,825		20	183	183	517	33
34	TOTAL (lines 1 thru 33)		\$ 1,501,760	\$ 37,504		\$ 53,087	\$ 15,583	\$ 966,026	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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 12C, Carried Forward		\$ 1,501,760	\$ 37,504		\$ 53,087	\$ 15,583	\$ 966,026	1
2	Wiring Pump Motor	2003	815		20	82	82	231	2
3	Painting	2003	575		20	58	58	158	3
4	Vertical Blinds	2003	1,196		20	120	120	329	4
5	Metal Screen Repairs	2003	1,601		20	160	160	440	5
6	Parking Lot Repairs	2003	15,500		20	1,550	1,550	4,133	6
7	Painting	2003	770		20	77	77	205	7
8	Rear Door Mounts	2003	968		20	97	97	258	8
9	Electrical Installation	2003	14,804		20	1,480	1,480	3,824	9
10	Switch Installation	2003	2,775		20	278	278	763	10
11	Elevator Repairs	2003	3,998		20	400	400	900	11
12	Wiring In Business Office	2003	2,175		20	218	218	471	12
13	Cooler/Pipe Repairs	2003	3,800		20	380	380	823	13
14	Roof Repairs	2003	3,700		20	370	370	802	14
15	Roof Repairs	2003	14,500		20	1,450	1,450	3,021	15
16	Metal Doors	2003	755		20	76	76	157	16
17	Driveway	2003	2,690		20	269	269	560	17
18	Smoking Room Materials	2003	975		20	98	98	203	18
19	Vertical Blinds	2003	2,719		20	272	272	725	19
20	Sign Board	2003	800		20	80	80	200	20
21	Air Conditioners	2003	4,148		20	415	415	1,037	21
22	Valve Repairs	2003	514		20	51	51	133	22
23	Sprinkler Repairs	2003	573		20	57	57	148	23
24	Repair Freon Leaks	2003	1,506		20	151	151	351	24
25	Pull Station Repairs	2003	573		20	57	57	134	25
26	Boiler Repairs	2003	510		20	51	51	115	26
27	Condensor Pump Repairs	2003	695		20	70	70	156	27
28	Pump Repairs	2003	1,156		20	116	116	241	28
29	Door	2003	736		20	74	74	215	29
30	Office Renovations	2003	635		20	64	64	185	30
31	Hallway Repairs	2003	2,036		20	204	204	577	31
32	Utility Room Renovations	2003	1,057		20	106	106	273	32
33	Drive Gate	2003	2,045		20	205	205	511	33
34	TOTAL (lines 1 thru 33)		\$ 1,593,060	\$ 37,504		\$ 62,223	\$ 24,719	\$ 988,305	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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 12D, Carried Forward		\$ 1,593,060	\$ 37,504		\$ 62,223	\$ 24,719	\$ 988,305	1
2	Pump Installation	2003	2,870		20	287	287	694	2
3	Roofing Repairs	2003	1,500		20	150	150	350	3
4	Smoking Room Renovations	2003	4,867		20	487	487	1,055	4
5	Bathroom Repairs	2003	4,082		20	408	408	1,055	5
6	Fence/Gate Installation	2003	1,278		20	128	128	351	6
7	Parking Lot	2003	2,850		20	285	285	736	7
8	Laundry/Physicain Office Repairs	2003	1,008		20	101	101	235	8
9	Motor	2003	680		20	68	68	159	9
10	Business Office/Utility Room Renovation	2003	6,511		20	651	651	1,411	10
11	Fence/Gate Repairs	2003	764		20	76	76	166	11
12	Parking Lot Repairs	2003	1,000		20	100	100	208	12
13	Bathroom Renovations	2003	1,204		20	120	120	251	13
14	Land Improvements	2003	2,800		20	280	280	700	14
15	Light Fixtures	2003	613		20	61	61	153	15
16	Office/Bathroom Renovation	2003	2,266		20	227	227	510	16
17	Door Repair	2003	2,045		20	205	205	460	17
18	Fence	2004	12,580		20	1,258	1,258	1,782	18
19	Door Improvments	2004	538		20	54	54	108	19
20	Fire Escape Doors	2004	5,000		20	500	500	875	20
21	Plumbing Improvements	2004	23,293		20	2,329	2,329	2,523	21
22	Elevator Repairs	2004	645		20	65	65	129	22
23	Light Fixtures	2004	550		20	55	55	87	23
24	Light Fixtures	2004	550		20	55	55	83	24
25	Wallguards	2004	1,059		20	106	106	159	25
26	Painting Materials	2004	670		20	67	67	101	26
27	Fire Alarm Repairs	2004	9,378		20	938	938	1,329	27
28	Fire Extinguisher Installation	2004	2,059		20	206	206	292	28
29	Cove Base	2004	528		20	53	53	66	29
30	Boiler Installation	2004	10,330		20	1,033	1,033	1,119	30
31	Fence Repairs	2004	675		20	68	68	73	31
32	Wallguards	2004	511		20	51	51	64	32
33	Roof Repairs	2004	1,000		20	100	100	158	33
34	TOTAL (lines 1 thru 33)		\$ 1,698,764	\$ 37,504		\$ 72,795	\$ 35,291	\$ 1,005,747	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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 12E, Carried Forward		\$ 1,698,764	\$ 37,504		\$ 72,795	\$ 35,291	\$ 1,005,747	1
2	Roof Repairs	2004	30,000		20	3,000	3,000	4,750	2
3	Stainless Steel Car Station	2004	2,065		20	207	207	396	3
4	Wallguards	2004	518		20	52	52	99	4
5	Elevator Repairs	2004	780		20	78	78	150	5
6	Pump	2004	922		20	92	92	169	6
7	Activity/Utility/Exam Room Repairs	2004	28,174		20	2,817	2,817	4,930	7
8	Fire System Upgrade	2004	12,345		20	1,235	1,235	2,160	8
9	Fire Panel Repairs	2004	8,915		20	892	892	1,263	9
10	Fire System Repairs	2004	693		20	69	69	104	10
11	Smoking Room	2004	12,283		20	1,228	1,228	2,457	11
12	Sprinkler & Pendant Heads	2005	1,965		20	49	49	49	12
13	Surveillance Unit Cabling	2005	5,095		20	42	42	42	13
14	Fire Alarm System Programming	2005	8,400		20	70	70	70	14
15	Surveillance Unit Cable Installation	2005	1,000		20	8	8	8	15
16	Elevator Modernization	2005	23,260		20	97	97	97	16
17	Bathroom Plumbing	2005	34,202		20	998	998	998	17
18	Driveway & Ramps	2005	3,450		20	115	115	115	18
19	Install Metal Sheet To New Gate	2005	1,350		20	45	45	45	19
20	Iron Slide Gate	2005	10,470		20	349	349	349	20
21	New Water Pipe Lines In Building	2005	38,450		20	160	160	160	21
22	Paint	2005	2,260		20	113	113	113	22
23	Painting Labor	2005	3,390		20	170	170	170	23
24	Wooden Fence	2005	3,192		20	160	160	160	24
25	Radiator Rehab	2005	5,643		20	282	282	282	25
26	Fire Pump Repair	2005	1,700		20	85	85	85	26
27	Elevator - Split Hydraulic Packing	2005	1,565		20	78	78	78	27
28	Remodeling	2005	3,518		20	176	176	176	28
29	Remodeling	2005	1,694		20	85	85	85	29
30	Privacy Fence	2005	2,535		20	127	127	127	30
31	Razor & Barbed Wire For Fence	2005	1,000		20	50	50	50	31
32	Relocation & Installation Of Fence	2005	1,895		20	95	95	95	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,951,493	\$ 37,504		\$ 85,818	\$ 48,314	\$ 1,025,578	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12F, Carried Forward	\$ 1,951,493	\$ 37,504		\$ 85,818	\$ 48,314	\$ 1,025,578		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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17									17
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19									19
20									20
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22									22
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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)	\$ 1,951,493	\$ 37,504		\$ 85,818	\$ 48,314	\$ 1,025,578		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12G, Carried Forward	\$ 1,951,493	\$ 37,504		\$ 85,818	\$ 48,314	\$ 1,025,578		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)	\$ 1,951,493	\$ 37,504		\$ 85,818	\$ 48,314	\$ 1,025,578		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12H, Carried Forward		\$ 1,951,493	\$ 37,504		\$ 85,818	\$ 48,314	\$ 1,025,578	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		\$ 1,951,493	\$ 37,504		\$ 85,818	\$ 48,314	\$ 1,025,578	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12I, Carried Forward		\$ 1,951,493	\$ 37,504		\$ 85,818	\$ 48,314	\$ 1,025,578	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)		\$ 1,951,493	\$ 37,504		\$ 85,818	\$ 48,314	\$ 1,025,578	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12J, Carried Forward	\$ 1,951,493	\$ 37,504		\$ 85,818	\$ 48,314	\$ 1,025,578		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)	\$ 1,951,493	\$ 37,504		\$ 85,818	\$ 48,314	\$ 1,025,578		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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			1971	1971	\$ 140,000	\$		\$	\$	\$ 140,000	4
5											5
6											6
7											7
8											8
Improvement Type**											
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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sacred Heart Home

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 140,000	\$		\$	\$	\$ 140,000	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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		MADO Management Allocation	1988	1988	\$ 49,212	\$ 1,790	35	\$ 1,406	\$ (384)	\$ 14,060	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9		MADO Management Allocation		1995	1,141	227	20	57	(170)	600	9
10		MADO Management Allocation		1993	18,745	499	20	937	438	11,645	10
11		MADO Management Allocation		2000	2,803	-	20	140	140	774	11
12		MADO Management Allocation		2001	1,214	11	20	61	(50)	287	12
13		MADO Management Allocation		2002	1,910	-	20	173	173	643	13
14		MADO Management Allocation		2004	538	33	21	20	(13)	35	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sacred Heart Home

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	75,563	\$	2,560	\$	2,794	\$	134	\$	28,044	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sacred Heart Home # 0013334 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 270,811	\$ 14,549	\$ 20,536	\$ 5,987	10	\$ 196,674	71
72	Current Year Purchases	28,342	3,683	1,082	(2,601)	10	1,082	72
73	Fully Depreciated Assets	80,810				10	80,810	73
74								74
75	TOTALS	\$ 379,963	\$ 18,232	\$ 21,618	\$ 3,386		\$ 278,566	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1997 JEEP GRAND CHER	1998	\$ 24,457	\$ 1,774	\$	\$ (1,774)	5	\$ 24,456	76
77	Allocate MADO Mgmt		2005	44,705	2,941	6,731	3,790	5	33,980	77
78										78
79										79
80	TOTALS			\$ 69,162	\$ 4,715	\$ 6,731	\$ 2,016		\$ 58,436	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)		\$ 2,422,695	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 60,451	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 114,167	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 53,716	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 1,362,580	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	BOILER REPAIR - 1997	\$ 2,297	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 2,297	\$	\$	91

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.	_____ /2006	\$ _____
13.	_____ /2007	\$ _____
14.	_____ /2008	\$ _____

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: \$ 7,200 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	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	N/A	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental									13
14	TOTAL			\$		\$	\$		\$	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home# 0013334Report Period Beginning: 01/01/05

Ending:

12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05

(last day of reporting year)

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	\$ 847	\$ 847	1
2	Cash-Patient Deposits	7,411	7,411	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	479,289	495,154	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,410	33,410	6
7	Other Prepaid Expenses	35,385	35,749	7
8	Accounts Receivable (owners or related parties)	3,348,864	5,445,895	8
9	Other(specify): <u>See Attached Schedule</u>	7,075	7,075	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,912,281	\$ 6,025,541	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		140,000	14
15	Leasehold Improvements, at Historical Cost	1,400,653	1,400,653	15
16	Equipment, at Historical Cost	420,473	435,473	16
17	Accumulated Depreciation (book methods)	(1,072,058)	(1,227,058)	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): <u>See Attached Schedule</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 749,068	\$ 749,068	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,661,349	\$ 6,774,609	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 562,401	\$ 802,367	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	33,296	33,296	30
31	Accrued Taxes Payable (excluding real estate taxes)		1,800	31
32	Accrued Real Estate Taxes(Sch.IX-B)		7,540	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(332)	(332)	35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 595,365	\$ 844,671	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	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 595,365	\$ 844,671	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,065,984	\$ 5,929,938	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,661,349	\$ 6,774,609	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,161,408	1
2	Restatements (describe):		2
3	Expense Restatement	(21,723)	3
4	Income Restatement	8,185	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,147,870	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(81,886)	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)	\$ (81,886)	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)	\$ 4,065,984	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning: 01/01/05

Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,984,644	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,984,644	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	84,058	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)	\$ 84,058	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,068,702	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,612,577	31
32	Health Care	1,837,722	32
33	General Administration	1,216,470	33
B. Capital Expense			
34	Ownership	249,737	34
C. Ancillary Expense			
35	Special Cost Centers	139,912	35
36	Provider Participation Fee	94,170	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,150,588	40
41	Income before Income Taxes (line 30 minus line 40)**	(81,886)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (81,886)	43

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

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

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

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

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/05

Ending:

12/31/05

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	142	142	\$ 3,704	\$ 26.08	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,810	2,841	58,232	20.50	3
4	Licensed Practical Nurses	2,994	3,018	57,952	19.20	4
5	CNAs & Orderlies	73,544	79,632	646,773	8.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	944	963	11,566	12.01	9
10	Activity Assistants	18,272	19,552	133,211	6.81	10
11	Social Service Workers	4,986	5,548	49,336	8.89	11
12	Dietician	4,174	4,526	32,458	7.17	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	28,268	30,830	227,115	7.37	15
16	Dishwashers					16
17	Maintenance Workers	16,468	17,407	147,128	8.45	17
18	Housekeepers	41,255	44,502	331,610	7.45	18
19	Laundry	2,054	2,099	13,977	6.66	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,714	1,968	18,793	9.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	197,625	213,028	\$ 1,731,855 *	\$ 8.13	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	282	\$ 9,853	01-03	35
36	Medical Director	64	4,000	09-03	36
37	Medical Records Consultant	88	4,048	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	15	761	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,256	11-03	44
45	Social Service Consultant	104	5,801	12-03	45
46	Other(specify) <u>Dietary - Out Labor</u>	1,969	29,855	01-03	46
47	<u>Social Service - Outside Labor</u>	11,031	163,494	12-03	47
48	<u>Activity - Outside Labor</u>	48	4,006	11-03	48
49	TOTAL (lines 35 - 48)	13,649	\$ 224,074		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	12,707	\$ 350,489	10-03	50
51	Licensed Practical Nurses	10,296	285,604	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	23,003	\$ 636,093		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning: 01/01/05

Ending: 12/31/05

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	\$ 24,410	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance	44,952	Advertising: Employee Recruitment	20,392		
				FICA Taxes	132,487	Health Care Worker Background Check	2,010		
				Employee Health Insurance	2,942	(Indicate # of checks performed <u>201</u>)			
				Employee Meals	41,205	Dues, Licenses & Fees	3,177		
				Illinois Municipal Retirement Fund (IMRF)*		Advertising	716		
				401K Expenses	19	Allocate MADO	930		
TOTAL (agree to Schedule V, line 17, col. 1)			\$						
(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 - MADO Management			\$ 618,000				Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 618,000	TOTAL (agree to Schedule V, line 22, col.8)			\$ 246,015	TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type	Amount							
FR&R	Accounting	\$ 8,086							
Personnel Planners	Unemployment Consulting	2,034							
Wolf & Company	Accounting	5,494							
Gardner Carton and Douglas	Legal	58,808							
Pretzel & Stouffer	Legal	10,977							
HDSI	Data Processing	8,253							
TOTAL (agree to Schedule V, line 19, column 3)			\$ 93,652	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$2500 attach copy of invoices.)								\$ 1,452	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number Sacred Heart Home

Report Period Beginning: 01/01/05 Ending:

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2002	6 FY2003	7 FY2004	8 FY2005	9 FY2006	10 FY2007	11 FY2008	12 FY2009	13 FY2010
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (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? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,892 Line 10-2
- (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. \$ 94,170
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 41,205 Has any meal income been offset against related costs? No 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? 100% Ln 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT