

		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: 0027870

Facility Name: St Agnes HC and Rehab Center

Address: 1725 South Wabash Chicago 60616
 Number City Zip Code

County: Cook

Telephone Number: (312) 787-9400 **Fax #** (312) 787-9590

HFS ID Number: 363192742001

Date of Initial License for Current Owners: 07/26/83

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) Jeffrey K. Singer, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center

0027870 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 None

	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	171	Skilled (SNF)	171	62,415	1
2		Skilled Pediatric (SNF/PED)			2
3	26	Intermediate (ICF)	26	9,490	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	197	TOTALS	197	71,905	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	32,100	2,119	4,944	39,163	8
9	SNF/PED					9
10	ICF	22,624	838	123	23,585	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	54,724	2,957	5,067	62,748	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.27%

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 1/1/1983

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

YES Date 1/1/1983 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 26 and days of care provided 4,933

Medicare Intermediary Mutual Of Omaha

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 St Agnes HC and Rehab Center # 0027870 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	23,532	34,609	456,369	514,510		514,510	514,510			1
2	Food Purchase		504,198		504,198	(58,575)	445,623	(237)	445,386		2
3	Housekeeping	277,013	52,395	19,518	348,926		348,926	(277)	348,649		3
4	Laundry	199,964	45,408	10,850	256,222		256,222	(3,352)	252,870		4
5	Heat and Other Utilities			242,659	242,659		242,659	1,730	244,389		5
6	Maintenance	35,826		346,517	382,343		382,343	(6,926)	375,417		6
7	Other (specify):*										7
8	TOTAL General Services	536,335	636,610	1,075,913	2,248,858	(58,575)	2,190,283	(9,062)	2,181,221		8
	B. Health Care and Programs										
9	Medical Director			800	800		800		800		9
10	Nursing and Medical Records	1,592,484	(1,604)	1,694,501	3,285,381		3,285,381		3,285,381		10
10a	Therapy	28,689		2,512	31,201		31,201	(140)	31,061		10a
11	Activities	144,339	10,824	28,019	183,182		183,182		183,182		11
12	Social Services	52,370		28,834	81,204		81,204		81,204		12
13	CNA Training										13
14	Program Transportation			1,407	1,407		1,407		1,407		14
15	Other (specify):*			400	400		400		400		15
16	TOTAL Health Care and Programs	1,817,882	9,220	1,756,473	3,583,575		3,583,575	(140)	3,583,435		16
	C. General Administration										
17	Administrative			750,000	750,000		750,000	(575,476)	174,524		17
18	Directors Fees										18
19	Professional Services			29,701	29,701		29,701	5,259	34,960		19
20	Dues, Fees, Subscriptions & Promotions			70,687	70,687		70,687	(9,061)	61,626		20
21	Clerical & General Office Expenses	90,344	57,618	97,233	245,195		245,195	110,942	356,137		21
22	Employee Benefits & Payroll Taxes			299,338	299,338	58,575	357,913	(172)	357,741		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,409	1,409		1,409	143	1,552		24
25	Other Admin. Staff Transportation							5,320	5,320		25
26	Insurance-Prop.Liab.Malpractice			172,967	172,967		172,967	6,570	179,537		26
27	Other (specify):*							49,371	49,371		27
28	TOTAL General Administration	90,344	57,618	1,421,335	1,569,297	58,575	1,627,872	(407,104)	1,220,768		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,444,561	703,448	4,253,721	7,401,730		7,401,730	(416,306)	6,985,424		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 St Agnes HC and Rehab Center #0027870 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			71,061	71,061	71,061	77,368	148,429				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						273,305	273,305				32
33	Real Estate Taxes			229,097	229,097	229,097	3,605	232,702				33
34	Rent-Facility & Grounds			306,000	306,000	306,000	(306,000)					34
35	Rent-Equipment & Vehicles			8,963	8,963	8,963		8,963				35
36	Other (specify):*											36
37	TOTAL Ownership			615,121	615,121	615,121	48,278	663,399				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	163,674	596,173	330,748	1,090,595	1,090,595		1,090,595				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			9,829	9,829	9,829		9,829				41
42	Provider Participation Fee			107,858	107,858	107,858		107,858				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	163,674	596,173	448,435	1,208,282	1,208,282		1,208,282				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,608,235	1,299,621	5,317,277	9,225,133	9,225,133	(368,028)	8,857,105				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 St Agnes HC and Rehab Center

0027870

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	69,768	30		9
10	Interest and Other Investment Income	(29)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(237)	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	(592)	21		18
19	Entertainment				19
20	Contributions	(1,580)	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	(8,348)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(656)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(74,113)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (15,787)		\$	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)	(352,241)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (352,241)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (368,028)		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	Reference
1	PPA - Laundry	\$ (3,352) 04 1
2	PPA - Office	(26) 21 2
3	PPA - Salaries	(140) 10a 3
4	PPA - Housekeeping	(277) 03 4
5	Annual Report Fee	(100) 20 5
6	Capitalized R&M	(10,154) 06 6
7	Bldg Co - Bank Charges	(62) 21 7
8	Bldg Co - Management Fees	(50,000) 17 8
9	Bank Charges	(14,370) 21 9
10	Trust Fees	(60) 20 10
11	PPA - Employee Benefits	(172) 22 11
12	Parking Income	(7,400) 32 12
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99		99
100		100
101	Total	(74,113) 101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Agnes HC and Rehab Center

0027870

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	(237)											(237)	2
3	Housekeeping	(277)											(277)	3
4	Laundry	(3,352)											(3,352)	4
5	Heat and Other Utilities			1,730									1,730	5
6	Maintenance	(10,154)		3,228									(6,926)	6
7	Other (specify):*													7
8	TOTAL General Services	(14,020)		4,958									(9,062)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy	(140)											(140)	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	(140)											(140)	16
	C. General Administration													
17	Administrative	(38,000)	38,000	(721,816)	89,140	57,200							(575,476)	17
18	Directors Fees													18
19	Professional Services			5,259									5,259	19
20	Fees, Subscriptions & Promotions	(10,088)		1,027									(9,061)	20
21	Clerical & General Office Expenses	(15,706)	62	126,586									110,942	21
22	Employee Benefits & Payroll Taxes	(172)											(172)	22
23	Inservice Training & Education													23
24	Travel and Seminar			143									143	24
25	Other Admin. Staff Transportation			5,320									5,320	25
26	Insurance-Prop.Liab.Malpractice			6,570									6,570	26
27	Other (specify):*			32,173	12,033	5,165							49,371	27
28	TOTAL General Administration	(63,966)	38,062	(544,738)	101,173	62,365							(407,104)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(78,126)	38,062	(539,780)	101,173	62,365							(416,306)	29

STATE OF ILLINOIS

Facility Name & ID Number St Agnes HC and Rehab Center

0027870

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	69,768	628	6,972									77,368	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(7,429)	244,558	36,176									273,305	32
33	Real Estate Taxes			3,605									3,605	33
34	Rent-Facility & Grounds		(306,000)										(306,000)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	62,339	(60,814)	46,753									48,278	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													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(15,787)	(22,752)	(493,027)	101,173	62,365							(368,028)	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			1721 Corp	Chicago, IL	Bldg Company
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	\$ 306,000	1721 Corp.	100.00%	\$	\$ (306,000)	1
2	V	32 Interest		1721 Corp.	100.00%	244,558	244,558	2
3	V	30 Depreciation		1721 Corp.	100.00%	628	628	3
4	V	17 Management Fees		1721 Corp.	100.00%	38,000	38,000	4
5	V	21 Bank Charges		1721 Corp.	100.00%	62	62	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		\$ 306,000			\$ 283,248	\$ * (22,752)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center# 0027870Report Period Beginning: 01/01/05Ending: 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%	\$ 1,730	\$ 1,730	15
16	V	6 REPAIRS AND MAINT.		MADO MGMT. LP		3,228	3,228	16
17	V	17 ADMINISTRATIVE		MADO MGMT. LP		28,184	28,184	17
18	V	19 PROFESSIONAL FEES		MADO MGMT. LP		5,259	5,259	18
19	V	20 DUES AND SUBSCRIPTIONS		MADO MGMT. LP		1,027	1,027	19
20	V	21 CLERICAL AND GENERAL		MADO MGMT. LP		126,586	126,586	20
21	V	24 SEMINARS		MADO MGMT. LP		143	143	21
22	V	25 AUTO EXPENSE		MADO MGMT. LP		5,320	5,320	22
23	V	26 PROPERTY INSURANCE		MADO MGMT. LP		6,570	6,570	23
24	V	27 GEN. ADMIN. - EMP. BEN.		MADO MGMT. LP		32,173	32,173	24
25	V	30 DEPRECIATION		MADO MGMT. LP		6,972	6,972	25
26	V	32 INTEREST		MADO MGMT. LP		36,176	36,176	26
27	V	33 REAL ESTATE TAXES		MADO MGMT. LP		3,605	3,605	27
28	V							28
29	V	17 MANAGEMENT FEES	750,000	MADO MGMT. LP			(750,000)	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		\$ 750,000			\$ 256,973	\$ * (493,027)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 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	17 SALARY-D. O'BRIEN	\$	MADO MGMT. LP	100.00%	\$ 44,570	\$ 44,570		15
16	V	27 EMP. BEN.-D. O'BRIEN		MADO MGMT. LP		5,279	5,279		16
17	V								17
18	V	17 SALARY-P. O'BRIEN		MADO MGMT. LP		44,570	44,570		18
19	V	27 EMP. BEN.-P. O'BRIEN		MADO MGMT. LP		6,754	6,754		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		\$			\$ 101,173	\$ *	101,173	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center# 0027870Report Period Beginning: 01/01/05Ending: 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						\$	15
16	V							16
17	V							17
18	V							18
19	V	17 ADMINISTRATIVE SALARY		MADO Management		57,200	57,200	19
20	V	21 CLERICAL SALARY		MADO Management				20
21	V	27 GEN. ADMIN. - EMP. BEN.		MADO Management		5,165	5,165	21
22	V	30 DEPRECIATION-WAREHOUSE		MADO Management				22
23	V	33 REAL ESTATE TAXES		MADO Management				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		\$			\$ 62,365	\$ *	62,365 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	03 DIETARY	\$ 36,627	Windy City Nursing	100.00%	\$ 36,627		15
16	V	11 ACTIVITIES	25,351	Windy City Nursing	100.00%	25,351		16
17	V	12 SOCIAL SERVICES	23,141	Windy City Nursing	100.00%	23,141		17
18	V	10 NURSING	1,675,296	Windy City Nursing	100.00%	1,675,296		18
19	V	21 OFFICE	88,106	Windy City Nursing	100.00%	88,106		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		\$ 1,848,521			\$ 1,848,521	\$ *	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	\$ 70,902	ST, AGNES MEDICAL EQUIPMENT	100.00%	\$ 70,902	\$	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			\$ 70,902			\$ 70,902	\$ *	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.

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 St Agnes HC and Rehab Center # 0027870 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	6.30	15.75%	See Attached	\$ 44,570	17-7	1
2	Peter O'Brien	Owner	Administrative	60.00%	See Attached	12.10	20.17%	See Attached	44,570	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 89,140		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 St Agnes HC and Rehab Center

0027870

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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 St Agnes HC and Rehab Center

0027870

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	\$ 62,748	\$ 1,730	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	239,337	5	12,313	62,748	3,228	2
3	17	ADMINISTRATIVE	PATIENT DAYS	239,337	5	107,500	107,500	28,184	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	239,337	5	20,060	62,748	5,259	4
5	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	239,337	5	3,917	62,748	1,027	5
6	21	CLERICAL AND GENERAL	PATIENT DAYS	239,337	5	482,833	418,211	126,586	6
7	24	SEMINARS	PATIENT DAYS	239,337	5	544	62,748	143	7
8	25	AUTO EXPENSE	PATIENT DAYS	239,337	5	20,290	62,748	5,320	8
9	26	PROPERTY INSURANCE	PATIENT DAYS	239,337	5	25,061	62,748	6,570	9
10	27	GEN. ADMIN. - EMP. BEN.	PATIENT DAYS	239,337	5	122,717	62,748	32,173	10
11	30	DEPRECIATION	PATIENT DAYS	239,337	5	26,595	62,748	6,972	11
12	32	INTEREST	PATIENT DAYS	239,337	5	137,986	62,748	36,176	12
13	33	REAL ESTATE TAXES	PATIENT DAYS	239,337	5	13,749	62,748	3,605	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	\$ 256,973	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center

0027870

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	44,570	1
2	27	EMP. BEN.-D. O'BRIEN	AVG. HOURS WORKED 24	5	20,137		6	5,279	2
3									3
4	17	SALARY-P. O'BRIEN	AVG. HOURS WORKED 46	5	170,000	170,000	12	44,570	4
5	27	EMP. BEN.-P. O'BRIEN	AVG. HOURS WORKED 46	5	25,761		12	6,754	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		\$ 101,173	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center

0027870

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		57,200	5
6	21	CLERICAL SALARY	DIRECT ALLOCATION	2	52,600	52,600			6
7	27	GEN. ADMIN. - EMP. BEN.	DIRECT ALLOCATION	5	64,126			5,165	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		\$ 62,365	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center

0027870

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
 City / State / Zip Code Chicago, IL 60601
 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	03	DIETARY	Direct Allocation		\$	\$		\$ 36,627	1
2	11	ACTIVITIES	Direct Allocation					25,351	2
3	12	SOCIAL SERVICES	Direct Allocation					23,141	3
4	10	NURSING	Direct Allocation					1,675,296	4
5	21	OFFICE	Direct Allocation					88,106	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				\$	\$		\$ 1,848,521	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center

0027870

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 Equipment
 Street Address 1541 N. Wells
 City / State / Zip Code Chicago, IL 60601
 Phone Number (312) 787-9400
 Fax Number (312) 787-9434

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING SUPPLIES	DIRECT ALLOCATION		\$	\$		\$ 70,902	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				\$	\$		\$ 70,902	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center

0027870

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 St Agnes HC and Rehab Center

0027870

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 St Agnes HC and Rehab Center

0027870

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 St Agnes HC and Rehab Center

0027870

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									5										
Working Capital																				
6										6										
7										7										
8	See Supplemental Schedule									8										
9	TOTAL Facility Related					\$	\$ 2,818,904		\$ 280,734	9										
B. Non-Facility Related*																				
10	Interest Income		X						(29)	10										
11	Parking Income		X						(7,400)	11										
12										12										
13	See Supplemental Schedule									13										
14	TOTAL Non-Facility Related					\$	\$		(7,429)	14										
15	TOTALS (line 9+line14)					\$	\$ 2,818,904		\$ 273,305	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.)

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	St. Agnes Medical Equipment		X	Working Capital			\$	35,000		\$	8									
9	Building Company		X	Working Capital				2,783,904			244,558	9								
10	Alloc-MADO Management		X								36,176	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.)

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 St Agnes HC and Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0027870

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>17-22-301-014</u>	<u>Long Term Care</u>	\$ <u>9,660.59</u>	\$ <u>9,660.59</u>
2. <u>17-22-301-015</u>	<u>Long Term Care</u>	\$ <u>27,933.75</u>	\$ <u>27,933.75</u>
3. <u>17-22-301-016</u>	<u>Long Term Care</u>	\$ <u>118,153.49</u>	\$ <u>118,153.49</u>
4. <u>17-22-301-017</u>	<u>Long Term Care</u>	\$ <u>56,787.15</u>	\$ <u>56,787.15</u>
5. <u>17-22-301-050</u>	<u>Long Term Care</u>	\$ <u>11,451.20</u>	\$ <u>11,451.20</u>
6. <u>See Attached</u>	<u>Home Office Allocation</u>	\$ <u>13,748.98</u>	\$ <u>3,604.64</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>237,735.16</u>	\$ <u>227,590.82</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.

Facility Name & ID Number St Agnes HC and Rehab Center

0027870 Report Period Beginning:

01/01/05 Ending:

12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 68,975 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>31,879</u>		<u>\$ 75,250</u>	1
2					2
3	TOTALS	31,879		\$ 75,250	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center

0027870

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			1983	1,400,995		20			1,333,294	9
10	Various			1984	132,601		20			132,601	10
11	Various			1986	21,150		20			21,150	11
12	Various			1987	10,000		20			10,000	12
13	Various			1989	72,045		20	3,603	3,603	51,506	13
14	Various			1990	150,700		20	7,329	7,329	99,596	14
15	Various			1991	37,665		20	1,883	1,883	24,387	15
16	Various			1992	45,688		20	2,285	2,285	22,887	16
17	Various			1993	56,127		20	2,806	2,806	30,207	17
18	Various			1994	133,605		20	6,681	6,681	69,871	18
19	Various			1995	110,000		20	7,790	7,790	81,417	19
20	Various			1996	192,259		20	9,616	9,616	90,569	20
21	Various			1997	244,818		20	12,243	12,243	104,135	21
22	Various			1998	312,914		20	15,649	15,649	118,193	22
23	Various			1999	387,533		20	19,381	19,381	116,271	23
24	Various			2000	69,634		20	3,484	3,484	17,701	24
25	Various			2001	107,788		20	5,395	5,395	24,968	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											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 St Agnes HC and Rehab Center

0027870

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	Related Building Company (Pages 12-BLDG & 12A-BLDG)	424,750					424,750	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)	83,441	2,827		3,275	448	30,967	68
69	Financial Statement Depreciation		71,688			(71,688)		69
70	TOTAL (lines 4 thru 69)	\$ 3,993,713	\$ 74,515		\$ 101,420	\$ 26,905	\$ 2,804,470	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St Agnes HC and Rehab Center

0027870

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 12A, Carried Forward		\$ 3,993,713	\$ 74,515		\$ 101,420	\$ 26,905	\$ 2,804,470	1
2	Vertical Blinds	2002	4,176		20	418	418	1,670	2
3	Elevator	2002	27,500		20	1,375	1,375	5,271	3
4	Air Conditioner	2002	2,704		20	225	225	826	4
5	Smoke Detector Alarm Systems	2002	796		20	114	114	455	5
6	Water Gallon Extinguisher Repair	2002	623		20	89	89	356	6
7	Repair Fire Alarm Systems	2002	646		20	92	92	369	7
8	Door Closer Repairs	2002	611		20	61	61	244	8
9	Fire Alarm Wiring Repairs	2002	600		20	86	86	336	9
10	Fire Pumps	2002	1,520		20	217	217	814	10
11	Water Heater Repairs	2002	1,830		20	153	153	559	11
12	Landscaping	2002	564		20	38	38	132	12
13	Ac Outlet Repairs	2002	880		20	88	88	308	13
14	Parking Lot Improvements	2002	850		20	57	57	189	14
15	Sink Line Repairs	2002	635		20	64	64	212	15
16	Wire Repairs	2002	750		20	75	75	244	16
17	Smoke Detectors	2003	514		20	73	73	220	17
18	Heating Motor	2003	975		20	81	81	230	18
19	Passenger Elevator	2003	3,260		20	163	163	435	19
20	Tiles	2003	991		20	99	99	264	20
21	Landscaping	2003	723		20	48	48	125	21
22	Smoke Detectors	2003	1,383		20	198	198	510	22
23	Pump Repairs	2003	510		20	51	51	128	23
24	Outlet Installation	2003	2,765		20	277	277	576	24
25	Gas Valve Replacement	2003	725		20	73	73	163	25
26	Metal Door	2003	543		20	54	54	154	26
27	Fence Repairs	2004	1,000		20	100	100	200	27
28	Shower Room Repairs	2004	671		20	67	67	134	28
29	Elevator Repairs	2004	2,873		20	144	144	287	29
30	Smoke Detectors	2004	747		20	75	75	143	30
31	Ac Sensor Repairs	2004	1,450		20	145	145	230	31
32	Smoke Detectors	2004	825		20	83	83	131	32
33	Ceiling Repairs	2004	1,515		20	152	152	227	33
34	TOTAL (lines 1 thru 33)		\$ 4,059,868	\$ 74,515		\$ 106,455	\$ 31,940	\$ 2,820,612	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St Agnes HC and Rehab Center

0027870

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 12B, Carried Forward		\$ 4,059,868	\$ 74,515		\$ 106,455	\$ 31,940	\$ 2,820,612	1
2	Fire Alarm Repairs	2004	525		20	53	53	74	2
3	Compressor Motor	2004	5,747		20	575	575	814	3
4	Blinds	2004	2,901		20	290	290	411	4
5	Blinds	2004	3,581		20	358	358	388	5
6	Rooftop Compressor Repairs'	2004	13,610		20	1,361	1,361	1,701	6
7	Pumps	2004	6,800		20	680	680	850	7
8	Rooftop Ventilators	2004	5,970		20	597	597	995	8
9	Pump Motor	2004	1,230		20	123	123	154	9
10	Doors	2004	1,220		20	122	122	203	10
11	Elevator Recall Fire Alarm System	2005	14,085		20	352	352	352	11
12	Door Closer - Fire Alarm System	2005	2,316		20	29	29	29	12
13	Compressor	2005	13,493		20	281	281	281	13
14	Wiring To Generator For Ventilators	2005	6,875		20	115	115	115	14
15	Circuit Breaker	2005	8,795		20	147	147	147	15
16	Fencing	2005	2,200		20	9	9	9	16
17	Boiler Room Repairs	2005	1,795		20	90	90	90	17
18	Painting Halls And Walls	2005	1,934		20	97	97	97	18
19	Elevator Repairs	2005	3,625		20	181	181	181	19
20	Concrete Wall Removal	2005	2,800		20	140	140	140	20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,159,370	\$ 74,515		\$ 112,055	\$ 37,540	\$ 2,827,643	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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	\$ 4,159,370	\$ 74,515		\$ 112,055	\$ 37,540	\$ 2,827,643		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 4,159,370	\$ 74,515		\$ 112,055	\$ 37,540	\$ 2,827,643		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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	\$ 4,159,370	\$ 74,515		\$ 112,055	\$ 37,540	\$ 2,827,643		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 4,159,370	\$ 74,515		\$ 112,055	\$ 37,540	\$ 2,827,643		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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	
1		\$ 4,159,370	\$ 74,515		\$ 112,055	\$ 37,540	\$ 2,827,643	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,159,370	\$ 74,515		\$ 112,055	\$ 37,540	\$ 2,827,643	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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	\$ 4,159,370	\$ 74,515		\$ 112,055	\$ 37,540	\$ 2,827,643		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 4,159,370	\$ 74,515		\$ 112,055	\$ 37,540	\$ 2,827,643		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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	\$ 4,159,370	\$ 74,515		\$ 112,055	\$ 37,540	\$ 2,827,643		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 4,159,370	\$ 74,515		\$ 112,055	\$ 37,540	\$ 2,827,643		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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	\$ 4,159,370	\$ 74,515		\$ 112,055	\$ 37,540	\$ 2,827,643		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 4,159,370	\$ 74,515		\$ 112,055	\$ 37,540	\$ 2,827,643		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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	\$ 4,159,370	\$ 74,515		\$ 112,055	\$ 37,540	\$ 2,827,643		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 4,159,370	\$ 74,515		\$ 112,055	\$ 37,540	\$ 2,827,643		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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	
1		\$ 4,159,370	\$ 74,515		\$ 112,055	\$ 37,540	\$ 2,827,643	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,159,370	\$ 74,515		\$ 112,055	\$ 37,540	\$ 2,827,643	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St Agnes HC and Rehab Center

0027870

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	197		1983	1983	\$ 424,750	\$	35	\$	\$	\$ 424,750	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 St Agnes HC and Rehab Center

0027870

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								67		
68								68		
69								69		
70	TOTAL (lines 4 thru 69)	\$	424,750	\$		\$		\$	424,750	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St Agnes HC and Rehab Center

0027870

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			1988	1988	\$ 54,342	\$ 1,976	35	\$ 1,553	\$ (423)	\$ 15,526	4
5											5
6											6
7											7
8											8
Improvement Type**											
9		Allocated - MADO Management		1993	20,699	551	20	1,035	484	12,859	9
10		Allocated - MADO Management		1995	1,260	251	20	251		662	10
11		Allocated - MADO Management		2000	3,096	-	20	155	155	855	11
12		Allocated - MADO Management		2001	1,341	13	20	67	(54)	317	12
13		Allocated - MADO Management		2002	2,109	-	20	191	191	710	13
14		Allocated - MADO Management		2004	594	36	20	23	(13)	38	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 St Agnes HC and Rehab Center

0027870

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								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	83,441	\$	2,827	\$	3,275	\$	340	\$	30,967	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 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	\$ 248,405	\$ 898	\$ 28,370	\$ 27,472	10	\$ 147,309	71
72	Current Year Purchases	7,713		571	571	10	571	72
73	Fully Depreciated Assets	454,998				10	18,715	73
74								74
75	TOTALS	\$ 711,116	\$ 898	\$ 28,941	\$ 28,043		\$ 166,595	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		1995 JEEP LAREDO	1995	\$ 25,368	\$	\$	\$	5	\$ 18,321	76
77		Allocated - MADO Management		49,365	3,248	7,433	4,185	5	37,522	77
78										78
79										79
80	TOTALS			\$ 74,733	\$ 3,248	\$ 7,433	\$ 4,185		\$ 55,843	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)	\$ 5,020,469	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 78,661	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 148,429	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 69,768	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,050,081	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

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: \$ 8,963 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 checked="" type="checkbox"/> YES <input 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		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$ 400	\$ 400
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	\$	\$	\$ 400	\$ 400
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	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	1

- (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	39 - 01	hrs	14,753		47,351			62,104	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			71,723			71,723	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				140,149		140,149	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39 - 02					162,053		162,053	12
13	Other (specify): <u>See Supplemental</u>			148,921		211,674	293,971		654,566	13
14	TOTAL			\$ 163,674		\$ 330,748	\$ 596,173		\$ 1,090,595	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 St Agnes HC and Rehab Center# 0027870Report 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	\$ 239,683	\$ 242,896	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,028,403	1,028,403	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	55,654	55,654	6
7	Other Prepaid Expenses	5,922	5,922	7
8	Accounts Receivable (owners or related parties)	2,277,333	5,608,243	8
9	Other(specify): <u>See Attached Schedule</u>	24,207	24,207	9
	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,631,202	\$ 6,965,325	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		75,250	13
14	Buildings, at Historical Cost		452,159	14
15	Leasehold Improvements, at Historical Cost	3,520,838	4,474,371	15
16	Equipment, at Historical Cost	259,461	266,754	16
17	Accumulated Depreciation (book methods)	(1,947,459)	(4,649,218)	17
18	Deferred Charges		1,288,774	18
19	Organization & Pre-Operating Costs		48,587	19
	Accumulated Amortization - Organization & Pre-Operating Costs		(48,587)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>		17,939	23
	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,832,840	\$ 1,926,029	24
	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,464,042	\$ 8,891,354	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 512,653	\$ 512,655	26
27	Officer's Accounts Payable	4,309,762	5,385,535	27
28	Accounts Payable-Patient Deposits	42,040	42,040	28
29	Short-Term Notes Payable	35,000	2,818,904	29
30	Accrued Salaries Payable	54,320	54,320	30
	Accrued Taxes Payable (excluding real estate taxes)	1,788	1,788	31
32	Accrued Real Estate Taxes(Sch.IX-B)	235,185	235,185	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(505)	(505)	35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	1,832	1,832	36
37				37
	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,192,075	\$ 9,051,754	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
	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,192,075	\$ 9,051,754	46
47	TOTAL EQUITY (page 18, line 24)	\$ 271,967	\$ (160,400)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,464,042	\$ 8,891,354	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (11,354)	1
2	Restatements (describe):		2
3	Expense Restatement	285,066	3
4	Income Restatement	(528)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 273,184	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,217)	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)	\$ (1,217)	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)	\$ 271,967	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center# 0027870Report Period Beginning: 01/01/05Ending: 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	\$ 8,227,218	1
2	Discounts and Allowances for all Levels	(209,951)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,017,267	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	555,607	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 555,607	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		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	157,951	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	21,264	19
20	Radiology and X-Ray	5,827	20
21	Other Medical Services	458,571	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 643,613	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	29	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 29	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	7,400	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,400	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,223,916	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,248,858	31
32	Health Care	3,583,575	32
33	General Administration	1,569,297	33
B. Capital Expense			
34	Ownership	615,121	34
C. Ancillary Expense			
35	Special Cost Centers	1,100,424	35
36	Provider Participation Fee	107,858	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,225,133	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,217)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,217)	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 St Agnes HC and Rehab Center

0027870

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	579	594	\$ 19,143	\$ 32.23	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,208	2,221	51,118	23.02	3
4	Licensed Practical Nurses	9,815	10,151	192,284	18.94	4
5	CNAs & Orderlies	154,099	164,888	1,315,081	7.98	5
6	CNA Trainees					6
7	Licensed Therapist	8,011	8,636	163,674	18.95	7
8	Rehab/Therapy Aides			28,689		8
9	Activity Director	5,292	5,549	47,165	8.50	9
10	Activity Assistants	11,764	12,869	97,174	7.55	10
11	Social Service Workers	5,773	6,248	52,370	8.38	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	2,125	2,345	23,532	10.03	15
16	Dishwashers					16
17	Maintenance Workers	4,637	4,877	35,826	7.35	17
18	Housekeepers	37,738	40,599	277,013	6.82	18
19	Laundry	28,898	30,350	199,964	6.59	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,155	11,183	90,344	8.08	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	1,893	2,029	14,858	7.32	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	282,987	302,539	\$ 2,608,235 *	\$ 8.62	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	468	\$ 16,153	01-03	35
36	Medical Director	40	800	09-03	36
37	Medical Records Consultant	96	4,224	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	38	1,901	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	56	2,668	11-03	44
45	Social Service Consultant	102	5,693	12-03	45
46	Other(specify)				46
47	<u>See Attached</u>	53,603	491,220	Various	47
48					48
49	TOTAL (lines 35 - 48)	54,403	\$ 522,659		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	44,683	\$ 1,659,640	10-03	50
51	Licensed Practical Nurses	17,489	18,727	10-03	51
52	Certified Nurse Assistants/Aides	8,093	10,009	10-03	52
53	TOTAL (lines 50 - 52)	70,265	\$ 1,688,376		53

SEE ACCOUNTANTS' COMPILATION REPORT

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													
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17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center

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? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (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. \$ 60,549 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 _____ 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. \$ 107,858
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? _____ 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? No
- (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. \$ 58,575 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? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT