

Facility Name & ID Number Sacred Heart Home

0013334 Report Period Beginning: 01/01/09 Ending: 12/31/09

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>54,011</u>	<u>61</u>		<u>54,072</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>54,011</u>	<u>61</u>		<u>54,072</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.13%

D. How many bed-hold days during this year were paid by the Department? 501 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 07/01/1971

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Sacred Heart Home # 0013334 Report Period Beginning: 01/01/09 Ending: 12/31/09

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	295,715	27,739	27,394	350,848		350,848		350,848		1
2	Food Purchase		371,550		371,550	(39,657)	331,893	(4)	331,889		2
3	Housekeeping	311,605	110,788		422,393		422,393	(4,035)	418,358		3
4	Laundry	47,492	32,206		79,698		79,698	(1,229)	78,469		4
5	Heat and Other Utilities			147,227	147,227		147,227	1,815	149,042		5
6	Maintenance	161,496		185,133	346,629		346,629	21,401	368,030		6
7	Other (specify):*										7
8	TOTAL General Services	816,308	542,283	359,754	1,718,345	(39,657)	1,678,688	17,948	1,696,636		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,195,081	46,066	288,899	1,530,046		1,530,046		1,530,046		10
10a	Therapy										10a
11	Activities	303,563	50,383	3,462	357,408		357,408	(120)	357,288		11
12	Social Services	164,114	764	81,507	246,385		246,385	(2,205)	244,180		12
13	CNA Training										13
14	Program Transportation			1,373	1,373		1,373		1,373		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,662,758	97,213	381,241	2,141,212		2,141,212	(2,325)	2,138,887		16
	C. General Administration										
17	Administrative			673,052	673,052		673,052	(509,558)	163,494		17
18	Directors Fees										18
19	Professional Services			42,591	42,591		42,591	(9,504)	33,087		19
20	Dues, Fees, Subscriptions & Promotions			27,250	27,250		27,250	(557)	26,693		20
21	Clerical & General Office Expenses	18,372	27,572	70,978	116,922		116,922	102,681	219,603		21
22	Employee Benefits & Payroll Taxes			325,265	325,265	39,657	364,922	(9,113)	355,809		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			1,254	1,254		1,254	4,581	5,835		25
26	Insurance-Prop.Liab.Malpractice			116,890	116,890		116,890	13,509	130,399		26
27	Other (specify):*							45,403	45,403		27
28	TOTAL General Administration	18,372	27,572	1,257,280	1,303,224	39,657	1,342,881	(362,558)	980,323		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,497,438	667,068	1,998,275	5,162,781		5,162,781	(346,935)	4,815,846		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Sacred Heart Home

#0013334

Report Period Beginning:

01/01/09

Ending:

12/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			185,440	185,440		185,440	(33,502)	151,938			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							9,074	9,074			32
33	Real Estate Taxes							9,144	9,144			33
34	Rent-Facility & Grounds			188,400	188,400		188,400	(188,400)				34
35	Rent-Equipment & Vehicles			9,023	9,023		9,023		9,023			35
36	Other (specify):*											36
37	TOTAL Ownership			382,863	382,863		382,863	(203,684)	179,179			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			1,904	1,904		1,904		1,904			40
41	Coffee and Gift Shops		45,637		45,637		45,637	(45,637)				41
42	Provider Participation Fee			94,170	94,170		94,170		94,170			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		45,637	96,074	141,711		141,711	(45,637)	96,074			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,497,438	712,705	2,477,212	5,687,355		5,687,355	(596,256)	5,091,099			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(38,910)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4)	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	(856)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,040)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(199)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(174,057)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (215,066)		\$	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)	(381,190)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (381,190)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (596,256)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Sacred Heart Home

ID# 0013334
Report Period Beginning: 01/01/09
Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Additional R&M	\$ 17,043	06	1
2	Vending Income	(45,637)	41	2
3	Bank Charges	(18,450)	21	3
4	2009 Annual Report	(100)	20	4
5	Non-Allowable Legal	(12,370)	19	5
6	Building Company - Management Fees	(90,000)	17	6
7	Building Company - Licenses & Fees	(50)	20	7
8	Building Company - Corporate Income Taxes	(537)	21	8
9	Building Company - Penalty	(1,138)	21	9
10	Building Company - Professional Fees	(1,764)	19	10
11	PPA - Employee Benefits	(9,113)	22	11
12	PPA - Professional Fees	(2,293)	19	12
13	PPA - Laundry	(1,229)	04	13
14	PPA - Housekeeping	(4,035)	03	14
15	PPA - Office Supplies	(1,550)	21	15
16	PPA - Acticity Outside Labor	(120)	11	16
17	PPA - Social Service Consultant	(2,205)	12	17
18	PPA - R&M	(510)	06	18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(174,057)		49

Sacred Heart Home

ID# 0013334

Report Period Beginning: 01/01/09

Ending: 12/31/09

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sacred Heart Home# 0013334

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(4)											(4)	2
3	Housekeeping	(4,035)											(4,035)	3
4	Laundry	(1,229)											(1,229)	4
5	Heat and Other Utilities			1,815									1,815	5
6	Maintenance	16,533		4,868									21,401	6
7	Other (specify):*													7
8	TOTAL General Services	11,265		6,683									17,948	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities	(120)											(120)	11
12	Social Services	(2,205)											(2,205)	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(2,325)											(2,325)	16
	C. General Administration													
17	Administrative	(90,000)	90,000	(509,558)									(509,558)	17
18	Directors Fees													18
19	Professional Services	(16,426)	1,764	5,158									(9,504)	19
20	Fees, Subscriptions & Promotions	(1,190)	50	583									(557)	20
21	Clerical & General Office Expenses	(22,730)	1,675	123,736									102,681	21
22	Employee Benefits & Payroll Taxes	(9,113)											(9,113)	22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation			4,581									4,581	25
26	Insurance-Prop.Liab.Malpractice			13,509									13,509	26
27	Other (specify):*			45,403									45,403	27
28	TOTAL General Administration	(139,459)	93,489	(316,588)									(362,558)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(130,519)	93,489	(309,905)									(346,935)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	(38,910)		5,408									(33,502)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest			9,074									9,074	32
33	Real Estate Taxes		4,744	4,400									9,144	33
34	Rent-Facility & Grounds		(188,400)										(188,400)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	(38,910)	(183,656)	18,882									(203,684)	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	(45,637)											(45,637)	41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	(45,637)											(45,637)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(215,066)	(90,167)	(291,023)									(596,256)	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%	See Attached		See Attached		
Daniel O'Brien	20%					
Mary O'Brien	20%					

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 188,400	Long Term Care	100.00%	\$	(188,400)	1
2	V	33 Real Estate Taxes		Long Term Care	100.00%	4,744	4,744	2
3	V	17 Management Fees		Long Term Care	100.00%	90,000	90,000	3
4	V	20 Licenses & Fees		Long Term Care	100.00%	50	50	4
5	V	21 Corporate Income Taxes		Long Term Care	100.00%	537	537	5
6	V	21 Penalty		Long Term Care	100.00%	1,138	1,138	6
7	V	19 Professional Fee		Long Term Care	100.00%	1,764	1,764	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 188,400			\$ 98,233	\$ * (90,167)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 UTILITIES	\$	MADO MGMT. LP	100.00%	\$ 1,815	\$ 1,815
16	V	6 REPAIRS AND MAINT.				4,868	4,868
17	V	17 ADMINISTRATIVE				28,932	28,932
18	V	19 PROFESSIONAL FEES				5,158	5,158
19	V	20 DUES AND SUBSCRIPTIONS				583	583
20	V	21 CLERICAL AND GENERAL				123,736	123,736
21	V	25 AUTO EXPENSE				4,581	4,581
22	V	26 PROPERTY INSURANCE				13,509	13,509
23	V	27 GEN. ADMIN. - EMP. BEN.				32,269	32,269
24	V	30 DEPRECIATION				5,408	5,408
25	V	32 INTEREST				9,074	9,074
26	V	33 REAL ESTATE TAXES				4,400	4,400
27	V						
28	V	17 MANAGEMENT FEES	618,000				(618,000)
29	V						
30	V	17 SALARY-P. O'BRIEN				43,398	43,398
31	V	27 EMP. BEN.-P. O'BRIEN				7,201	7,201
32	V						
33	V	17 ADMINISTRATIVE SALARY				36,112	36,112
34	V	21 CLERICAL SALARY					
35	V	27 GEN. ADMIN. - EMP. BEN.				5,933	5,933
36	V	30 DEPRECIATION-WAREHOUSE					
37	V	33 REAL ESTATE TAXES					
38	V						
39	Total		\$ 618,000			\$ 326,977	\$ * (291,023)

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

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning: 01/01/09

Ending: 12/31/09

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21 Office	\$ 94,543	Windy City Nursing	100.00%	\$ 94,543	\$	15
16	V	01 Dietary	9,075	Windy City Nursing	100.00%	9,075		16
17	V	12 Social Services	69,037	Windy City Nursing	100.00%	69,037		17
18	V	06 Maintenance	53,475	Windy City Nursing	100.00%	53,475		18
19	V	10 Nursing	241,523	Windy City Nursing	100.00%	241,523		19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 467,653			\$ 467,653	\$ *	39

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

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning: 01/01/09

Ending: 12/31/09

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

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning: 01/01/09

Ending: 12/31/09

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: 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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning: 01/01/09

Ending: 12/31/09

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning: 01/01/09

Ending: 12/31/09

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number

Sacred Heart Home

0013334

Report Period Beginning:

01/01/09

Ending:

12/31/09

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Peter O'Brien	Owner	Administrative	60.00%	See Attached	11.10	18.50%	Alloc. Salary	\$ 43,398	17-07	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 43,398		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/09

Ending: 12/31/09

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	224,274	5	\$ 7,527	\$ 54,072	\$ 1,815	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	224,274	5	20,191	54,072	4,868	2
3	17	ADMINISTRATIVE	PATIENT DAYS	224,274	5	120,000	120,000	28,932	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	224,274	5	21,395	54,072	5,158	4
5	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	224,274	5	2,417	54,072	583	5
6	21	CLERICAL AND GENERAL	PATIENT DAYS	224,274	5	513,219	454,362	123,736	6
7	25	AUTO EXPENSE	PATIENT DAYS	224,274	5	19,002	54,072	4,581	7
8	26	PROPERTY INSURANCE	PATIENT DAYS	224,274	5	56,030	54,072	13,509	8
9	27	GEN. ADMIN. - EMP. BEN.	PATIENT DAYS	224,274	5	133,841	54,072	32,269	9
10	30	DEPRECIATION	PATIENT DAYS	224,274	5	22,429	54,072	5,408	10
11	32	INTEREST	PATIENT DAYS	224,274	5	37,636	54,072	9,074	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	224,274	5	18,250	54,072	4,400	12
13									13
14									14
15									15
16	17	SALARY-P. O'BRIEN	AVG. HOURS WORKED	46	5	180,000	180,000	43,398	16
17	27	EMP. BEN.-P. O'BRIEN	AVG. HOURS WORKED	46	5	29,866	11	7,201	17
18									18
19	17	ADMINISTRATIVE SALARY	DIRECT ALLOCATION		5	286,839	286,839	36,112	19
20									20
21	27	GEN. ADMIN. - EMP. BEN.	DIRECT ALLOCATION		5	49,530		5,933	21
22	30	DEPRECIATION-WAREHOUSE	DIRECT ALLOCATION		1				22
23	33	REAL ESTATE TAXES	DIRECT ALLOCATION		1	2,716			23
24									24
25	TOTALS					\$ 1,520,888	\$ 1,041,201	\$ 326,977	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

WINDY CITY NURSING

Street Address

1541 N. WELLS ST.

City / State / Zip Code

CHICAGO, IL. 60610

Phone Number

(312) 787-9400

Fax Number

(312) 787-9434

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.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	21	Office		Direct Allocation		\$		\$ 94,543	1
2	1	Dietary		Direct Allocation				9,075	2
3	12	Social Services		Direct Allocation				69,037	3
4	6	Maintenance		Direct Allocation				53,475	4
5	10	Nursing		Direct Allocation				241,523	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$		\$ 467,653	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home

0013334 Report Period Beginning: 01/01/09 Ending: 12/31/09

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 Sacred Heart Home

0013334

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Sacred Heart Home

0013334

Report Period Beginning:

01/01/09

Ending:

12/31/09

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		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	Allocate: MADO Mgmt		X								9,074	6							
7												7							
8	See Supplemental Schedule											8							
9	TOTAL Facility Related						\$	\$			\$ 9,074	9							
	B. Non-Facility Related*																		
10												10							
11												11							
12												12							
13	See Supplemental Schedule											13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$	\$			\$ 9,074	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

Sacred Heart Home

0013334

Report Period Beginning:

01/01/09

Ending:

12/31/09

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																			
	Working Capital																			
8							\$	\$			\$	8								
9												9								
10												10								
11												11								
12												12								
13												13								
14	TOTAL Working Capital																			
	B. Non-Facility Related*																			
15							\$	\$			\$	15								
16												16								
17												17								
18												18								
19												19								
20	TOTAL Non-Facility Related																			

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and			
1. Real Estate Tax accrual used on 2008 report.		\$	20,395		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	9,095		2
3. Under or (over) accrual (line 2 minus line 1).		\$	(11,300)		3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	20,444		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	9,144		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2004	2,896	8	FOR BHF USE ONLY	
	2005	2,926	9	13	FROM R. E. TAX STATEMENT FOR 2008 \$ 13
	2006	4,698	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2007	4,648	11	15	LESS REFUND FROM LINE 6 \$ 15
	2008	4,695	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
Beginning Accrual Adjusted					
Allocated from MADDO Mgmt: \$4,400					

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/09

Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 79,940 B. General Construction Type: Exterior Frame Number of Stories 3

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

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

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

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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and an index column. Row 1: Facility, 22,077, 1. Row 2: (blank), 2. Row 3: TOTALS, 22,077, 3.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/09

Ending:

12/31/09

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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1973		9,000		20			9,000	9
10	Various		1975		16,880		20			16,880	10
11	Various		1976		4,234		20			4,234	11
12	Various		1977		43,234		20			43,234	12
13	Various		1978		50,867		20			50,867	13
14	Various		1979		40,393		20			40,393	14
15	Various		1980		4,392		20			4,392	15
16	Various		1981		15,817		20			15,817	16
17	Various		1982		15,180		20			15,180	17
18	Various		1984		7,505		20			7,505	18
19	Various		1985		60,377		20			60,377	19
20	Various		1986		41,792		20			41,792	20
21	Various		1987		17,344		20			17,344	21
22	Various		1988		13,840		20			13,824	22
23	Various		1989		10,568		20			10,568	23
24	Various		1990		48,324		20			48,324	24
25	Various		1991		26,113		20	132	132	25,785	25
26	Various		1992		105,671		20			105,671	26
27	Various		1993		14,487		20			14,487	27
28	Various		1994		37,950		20	1,898	1,898	30,364	28
29	Various		1995		38,705		20	1,935	1,935	27,092	29
30	Various		1996		34,431		20	1,721	1,721	24,430	30
31	Various		1997		62,792		20	3,143	3,143	39,111	31
32	Various		1998		73,236		20	3,664	3,664	43,049	32
33	Various		1999		51,272		20	2,563	2,563	26,847	33
34	Various		2000		120,486		20	6,028	6,028	57,969	34
35	Various		2001		159,720		20	7,992	7,992	67,533	35
36	Various		2002		148,315		20	14,259		112,624	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

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 Various	2003	\$ 140,910	\$	20	\$ 14,099	\$ 14,099	\$ 91,027	37
38 Various	2004	159,051		20	15,906	15,906	88,011	38
39 Various	2005	156,034		20	9,223	9,223	40,716	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 12F & 12G)		140,000					140,000	67
68 Related Party Allocations (Pages 12H & 12I)		76,733	2,563		2,844	281	39,852	68
69 Financial Statement Depreciation			185,440			(185,440)		69
70 TOTAL (lines 4 thru 69)		\$ 1,945,653	\$ 188,003		\$ 85,407	\$ (116,855)	\$ 1,374,299	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,945,653	\$ 188,003		\$ 85,407	\$ (102,596)	\$ 1,374,299	1
2	Remodel S.E. Bathroom	2006	27,290		20	2,729	2,729	8,414	2
3	West Fence Razor/Barb Wire	2006	4,000		20	400	400	1,500	3
4	1St Floor Hallway Remodel	2006	8,201		20	820	820	2,939	4
5	Resident Bathroom Remodel	2006	7,382		20	738	738	2,399	5
6	1St & 2Nd Floor Water Pipe Lines	2006	7,640		20	764	764	2,356	6
7	Sprinkler Reconfiguration Idph Req.	2006	13,669		20	1,367	1,367	4,443	7
8	Upgrade Electric	2006	33,785		20	3,379	3,379	12,106	8
9	Tiles For Bathroom Renovation	2006	3,862		20	386	386	1,320	9
10	Replace 5 Existing Panel To Run Circuits To Ac	2006	10,089		20	1,009	1,009	3,195	10
11	Roof Repair & New Roof At # 2 Section Of West Bldg	2006	3,800		20	380	380	1,172	11
12	New Compressor For Refrigerator	2006	3,085		20	309	309	1,234	12
13	Ceiling Replacement	2006	2,817		20	141	141	481	13
14	Pavement Patching	2006	6,225		20	311	311	1,038	14
15	Boiler Repair	2006	4,893		20	245	245	775	15
16	Vertical Blinds	2006	2,024		20	101	101	405	16
17	Fire Door	2006	1,520		20	76	76	298	17
18	Roof Repairs	2006	3,500		20	350	350	1,371	18
19	Water Pipes In Hallway & Bathroom	2006	2,860		20	286	286	1,096	19
20	Roof Repairs	2006	6,300		20	630	630	2,363	20
21	New Water Lines In Bathroom	2006	5,995		20	600	600	2,198	21
22	Replace S.E. Bathroom Pipes & Tiles	2006	7,775		20	778	778	2,786	22
23	Upgrade Water Lin For 1St & 2Nd Floors	2006	6,987		20	349	349	1,077	23
24	Labor & Mats. For Sprinkler Reconfiguration	2007	3,976		20	398	398	1,160	24
25	Upgrade Water Line For 1St & 2Nd Floors	2007	11,221		20	1,122	1,122	3,366	25
26	Exterior Doors Replacement	2007	4,807		20	481	481	1,322	26
27	Materials For Shower Room 3Rd Floor	2007	2,732		20	273	273	751	27
28	Cold Line From Activity Office To Storeroom	2007	2,970		20	297	297	842	28
29	Run Water Line	2007	2,750		20	275	275	802	29
30	Roof Repair & Replacement	2007	11,400		20	1,140	1,140	3,230	30
31	Labor & Mats. For Sprinkler Reconfiguration	2007	3,582		20	358	358	1,015	31
32	Run Water Line	2007	5,340		20	534	534	1,469	32
33	Upgraded & Replaced Doors For Resident Rooms	2007	2,778		20	278	278	741	33
34	TOTAL (lines 1 thru 33)		\$ 2,170,908	\$ 188,003		\$ 106,711	\$ (81,292)	\$ 1,443,963	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/09

Ending:

12/31/09

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		\$ 2,170,908	\$ 188,003		\$ 106,711	\$ (81,292)	\$ 1,443,963	1
2	Renovation Of Shower Room 3Rd Floor	2007	7,513		20	751	751	1,941	2
3	Labor Upgrade Pipes - Smoking Area, Bathroom & Boiler Room	2007	2,800		20	280	280	723	3
4	Roof Repair & Replacement	2007	2,750		20	275	275	710	4
5	Replaced Rotten Pipes In Boiler Room	2007	4,180		20	418	418	1,080	5
6	Pipes - Boiler Rm.	2007	6,985		20	699	699	1,746	6
7	Mats. - Total Renovation Of Res' Community Bathrooms 2Nd Flr	2007	4,125		20	413	413	963	7
8	Mats. Built Soc. Svc. & Group Rm. Behavioral Coord. Office	2007	6,571		20	657	657	1,533	8
9	Upgrade Heating Lines In Basement	2007	3,520		20	352	352	792	9
10	Water Lines - Hobby Room	2007	3,960		20	396	396	825	10
11	Labor - Water Lines 2Nd Floor North Bldg.	2007	4,840		20	484	484	1,008	11
12	Sprinkler Head Installations	2007	19,211		20	1,921	1,921	5,123	12
13	Ac Circuits - Residents Rooms	2007	12,920		20	1,292	1,292	3,015	13
14	Asbestos Removal	2007	3,500		20	175	175	481	14
15	Stainless Steel Sheets For Elevator Door	2008	552		20	28	28	53	15
16	Upgrade Water Lines - 2Nd Floor Bathroom	2008	17,045		20	852	852	1,349	16
17	Upgrade Water Lines - 2Nd Floor Bathrooms.	2008	14,040		20	702	702	761	17
18	Carpet	2008	1,374		20	69	69	74	18
19	Doors	2008	1,653		20	83	83	90	19
20	Upgrade Water Lines - 3Rd Floor Bathrooms	2008	10,106		20	505	505	547	20
21	Resident Room Doors	2008	2,520		20	126	126	241	21
22	Elevator Panels	2008	541		20	27	27	52	22
23	Motor For Elevator Cooling Pump	2008	1,035		20	52	52	86	23
24	Catch Basins & Sewer Line Upgrade	2008	10,609		20	530	530	840	24
25	Compressor	2008	1,985		20	99	99	157	25
26	Door Holders	2008	635		20	32	32	50	26
27	Power Supply - Exit Signs	2008	2,785		20	139	139	209	27
28	Replace Lintels - North Wall	2008	7,860		20	393	393	524	28
29	Metal Exit Door	2008	933		20	47	47	58	29
30	Window Blinds	2008	605		20	30	30	33	30
31	Door	2008	927		20	46	46	66	31
32	Screens For Entire Building	2008	1,445		20	72	72	84	32
33	Repairs In 2Nd Floor Bathrooms	2008	3,900		20	195	195	358	33
34	TOTAL (lines 1 thru 33)		\$ 2,334,333	\$ 188,003		\$ 118,851	\$ (69,152)	\$ 1,469,535	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/09

Ending:

12/31/09

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		\$ 2,334,333	\$ 188,003		\$ 118,851	\$ (69,152)	\$ 1,469,535	1
2	Roof Repair	2008	4,500		20	225	225	281	2
3	Tuckpointing Of Roof - South Side Of Bldg	2008	4,800		20	240	240	300	3
4	Pump Motor & Thermostatic Valve	2009	4,579		20	191	191	191	4
5	Cement And Exterior Lights For Courtyard	2009	5,266		20	176	176	176	5
6	Removal & Repaving Of Courtyard	2009	7,000		20	204	204	204	6
7	New Layer Of Hot Roofing Rubber	2009	4,700		20	118	118	118	7
8	Doors For Resident Rooms	2009	3,352		20	70	70	70	8
9	Hot Water Heater & Installation Supplies	2009	4,564		20	95	95	95	9
10	Removal Of Fire Escape	2009	32,500		20	677	677	677	10
11	Brickwork For Doorways & Windows	2009	4,500		20	75	75	75	11
12	Closure Of 12 Fire Exit Doors	2009	5,056		20	84	84	84	12
13	Replaced Broken Pipe; Paved Hole - Courtyard	2009	2,943		20	25	25	25	13
14	Upgrade Boiler Room & Sewer	2009	2,548		20	21	21	21	14
15	Labor - Conversion Of Hooby Room To Activity Room	2009	5,355		20	22	22	22	15
16	Labor - Electrical Work - Nurses Station Renovation	2009	16,040		20	67	67	67	16
17	2Nd & 3Rd Flr Bathrooms-Tiles, Shelves, Flushometer	2009	22,471		20	843	843	843	17
18	Covert Hobby Rm To Activiy Rm-Flooring, Walls, Paint, Ceiling	2009	9,875		20	123	123	123	18
19	2Nd Flr Nurses Station & Activity Rm-Tiles, Paint, Ceiling	2009	16,020		20	67	67	67	19
20	2Nd Floor Nurses Station & Bathroom - Fixtures, Paint, Doors	2009	5,690		20	95	95	95	20
21	Install & Paint Iron Fence & Gate	2009	3,900		20	33	33	33	21
22	Upgrade 2Nd Floor Nurses Station-Flooring, Wall Work	2009	7,633		20	64	64	64	22
23	Seal Fire Exit Doors Prior To Removal	2009	5,612		20	94	94	94	23
24	Upgrade Courtyard Gate	2009	2,754		20	11	11	11	24
25	Installation Of Exterior Lighting - Coutyard	2009	9,875		20	288	288	288	25
26	2Nd Flr Nurses Station-Flooring, New Wall, Cabinets/Counter To	2009	14,621		20	61	61	61	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,540,487	\$ 188,003		\$ 122,820	\$ (65,183)	\$ 1,473,620	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/09

Ending:

12/31/09

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		\$ 2,540,487	\$ 188,003		\$ 122,820	\$ (65,183)	\$ 1,473,620	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)	\$ 2,540,487	\$ 188,003		\$ 122,820	\$ (65,183)	\$ 1,473,620	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3	Long Term Care	1971	140,000					140,000	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

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		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
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19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (12F & 12G lines 1 thru 33)	\$ 140,000	\$		\$	\$	\$ 140,000

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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	MADO Management Allocation	1988	49,973	1,825	35	1,428	(397)	19,989	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	MADO Management Allocation	1995	1,159	231	20	58	(173)	841	9
10	MADO Management Allocation	1993	19,035	507	20	952	445	15,632	10
11	MADO Management Allocation	2000	2,847		20	142	142	1,355	11
12	MADO Management Allocation	2001	1,233		20	62	62	538	12
13	MADO Management Allocation	2002	1,940		20	175	175	1,353	13
14	MADO Management Allocation	2004	546		20	27	27	144	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/09

Ending:

12/31/09

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								1	
2								2	
3								3	
4								4	
5								5	
6								6	
7								7	
8								8	
9								9	
10								10	
11								11	
12								12	
13								13	
14								14	
15								15	
16								16	
17								17	
18								18	
19								19	
20								20	
21								21	
22								22	
23								23	
24								24	
25								25	
26								26	
27								27	
28								28	
29								29	
30								30	
31								31	
32								32	
33								33	
34	TOTAL (12H & 12I lines 1 thru 33)		\$ 76,733	\$ 2,563		\$ 2,844	\$ 281	\$ 39,852	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	\$ 285,614	\$ 61	\$ 20,035	\$ 19,974	10	\$ 217,883	71
72	Current Year Purchases	20,158		1,002	1,002	10	1,002	72
73	Fully Depreciated Assets	145,092				10	143,321	73
74								74
75	TOTALS	\$ 450,864	\$ 61	\$ 21,037	\$ 20,976		\$ 362,206	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1997 JEEP GRAND CHER	1998	\$ 24,457	\$	\$	\$	5	\$ 24,456	76
77		MADO Alloc.	2009	36,050	2,784	8,081	5,297	5	24,817	77
78										78
79										79
80	TOTALS			\$ 60,507	\$ 2,784	\$ 8,081	\$ 5,297		\$ 49,273	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,073,935	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 190,848	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 151,938	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (38,910)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,885,099	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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: \$ 9,023 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home# 0013334Report Period Beginning: 01/01/09Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(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	\$ 96,134	\$ 96,134	1
2	Cash-Patient Deposits	3,358	3,358	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	667,459	667,459	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,827	27,827	6
7	Other Prepaid Expenses	835	835	7
8	Accounts Receivable (owners or related parties)	1,869,523	4,698,888	8
9	Other(specify): <u>See Attached Schedule</u>	6,310	6,310	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,671,446	\$ 5,500,811	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		15,865	13
14	Buildings, at Historical Cost		140,000	14
15	Leasehold Improvements, at Historical Cost	1,997,225	1,997,225	15
16	Equipment, at Historical Cost	531,833	546,833	16
17	Accumulated Depreciation (book methods)	(1,484,405)	(1,639,405)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,044,653	\$ 1,060,518	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,716,099	\$ 6,561,329	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 443,103	\$ 443,102	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	84,872	84,872	30
31	Accrued Taxes Payable (excluding real estate taxes)	42	42	31
32	Accrued Real Estate Taxes(Sch.IX-B)		20,444	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes		(386)	35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>		614,959	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 528,017	\$ 1,163,033	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 528,017	\$ 1,163,033	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,188,082	\$ 5,398,296	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,716,099	\$ 6,561,329	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,153,215	1
2	Restatements (describe):		2
3	Late Journal Entries	(6,696)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,146,519	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	41,563	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)	\$ 41,563	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)	\$ 3,188,082	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning: 01/01/09

Ending: 12/31/09

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	\$ 5,664,714	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,664,714	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	64,204	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 64,204	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,728,918	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,718,345	31
32	Health Care	2,141,212	32
33	General Administration	1,303,224	33
B. Capital Expense			
34	Ownership	382,863	34
C. Ancillary Expense			
35	Special Cost Centers	47,541	35
36	Provider Participation Fee	94,170	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,687,355	40
41	Income before Income Taxes (line 30 minus line 40)**	41,563	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 41,563	43

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

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

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

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

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/09

Ending:

12/31/09

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,310	1,310	\$ 73,287	\$ 55.94	1
2	Assistant Director of Nursing	961	1,001	29,242	29.21	2
3	Registered Nurses	3,213	3,534	101,106	28.61	3
4	Licensed Practical Nurses	12,033	12,587	297,957	23.67	4
5	CNAs & Orderlies	58,982	64,966	693,489	10.67	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,648	2,834	43,925	15.50	9
10	Activity Assistants	27,630	29,210	259,638	8.89	10
11	Social Service Workers	12,020	12,726	164,114	12.90	11
12	Dietician	5,896	6,272	72,866	11.62	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,496	23,226	222,849	9.59	15
16	Dishwashers					16
17	Maintenance Workers	17,441	18,841	161,496	8.57	17
18	Housekeepers	31,723	34,967	311,605	8.91	18
19	Laundry	5,362	5,647	47,492	8.41	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,846	2,012	18,372	9.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	201,561	219,133	\$ 2,497,438 *	\$ 11.40	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	508	\$ 17,780	01-03	35
36	Medical Director	Monthly	6,000	09-03	36
37	Medical Records Consultant	96	4,320	10-03	37
38	Nurse Consultant	136	8,145	10-03	38
39	Pharmacist Consultant	10	500	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	48	2,316	11-03	44
45	Social Service Consultant	183	10,265	12-03	45
46	Other(specify) Dietary - O/S Labor	487	9,614	01-03	46
47	Social Service - O/S Labor	3,072	71,242	12-03	47
48	Activity - O/L Labor	293	1,146	11-03	48
49	TOTAL (lines 35 - 48)	4,833	\$ 131,328		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	2,502	\$ 81,669	10-03	50
51	Licensed Practical Nurses	6,512	194,265	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	9,014	\$ 275,934		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
			\$	Workers' Compensation Insurance	\$ 64,412	IDPH License Fee	\$	
				Unemployment Compensation Insurance	35,630	Advertising: Employee Recruitment	20,465	
				FICA Taxes	186,581	Health Care Worker Background Check	3,585	
				Employee Health Insurance	28,998	(Indicate # of checks performed <u>327</u>)		
				Employee Meals	39,657	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Licenses Dues & Fees	2,060	
				401K Employer's Share	531	Allocated: MADO Management	583	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)								
B. Administrative - Other								
Description			Amount					
Management Fees - MADO Management			\$ 618,000			Less: Public Relations Expense	()	
Outside Labor - Assistant Administrator			55,052			Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 673,052	TOTAL (agree to Schedule V, line 22, col.8)	\$ 355,809	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 26,693	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Frost, Ruttenberg & Rothblatt	Accounting		\$ 4,500				Out-of-State Travel	\$
Personnel Planners	Unemployment Cnsltg		1,664					
Wolf & Company	Accounting		7,920					
Maemar P.C.	Architectural Cnsltg		5,253				In-State Travel	
HDSI	Data Processing		10,884					
Various	Legal (Adj. on 5A)		12,370				Seminar Expense	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 42,591	TOTAL		\$	Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

(See instructions.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home

0013334

Report Period Beginning:

01/01/09

Ending:

12/31/09

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 47 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 94,170
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 39,657 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.