

		FOR BHF USE					

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**2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)**

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.

<p>I. IDPH License ID Number: <u>0027870</u></p> <p>Facility Name: <u>St. Agnes Manor Inc.</u></p> <p>Address: <u>1725 South Wabash</u> <u>Chicago</u> <u>60616</u> <small>Number City Zip Code</small></p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(312) 787-9400</u> Fax # <u>(312) 787-9590</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>07/26/83</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td style="width:33%"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236-1111</u> Email Address: _____</p>	<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 _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/11</u> to <u>12/31/11</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="vertical-align: top;">Paid Preparer</td> <td>(Signed) _____ (Date) _____ (Print Name and Title) <u>Jeffrey K. Singer, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>Jeffrey K. Singer, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Agnes Manor Inc.

0027870 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	171	Skilled (SNF)	171	70,810	1
2		Skilled Pediatric (SNF/PED)			2
3	26	Intermediate (ICF)	26	1,095	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 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	24,010	1,069	5,308	30,387	8
9	SNF/PED					9
10	ICF	22,843	2,074	7	24,924	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	46,853	3,143	5,315	55,311	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.92%

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 1/1/1993

J. Was the facility purchased or leased after January 1, 1978?
YES Date 1/1/1993 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 93 and days of care provided 5,308

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number St. Agnes Manor Inc. # 0027870 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	459,974	48,728	109,193	617,895		617,895		617,895		1
2	Food Purchase		524,920		524,920	(68,255)	456,665	(298)	456,367		2
3	Housekeeping	288,894	105,181		394,075		394,075		394,075		3
4	Laundry	139,895	37,971		177,866		177,866		177,866		4
5	Heat and Other Utilities			234,597	234,597		234,597	2,269	236,866		5
6	Maintenance	201,832		160,596	362,428		362,428	7,877	370,305		6
7	Other (specify):*										7
8	TOTAL General Services	1,090,595	716,800	504,386	2,311,781	(68,255)	2,243,526	9,848	2,253,374		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	2,836,978	42,948	1,140,740	4,020,666		4,020,666		4,020,666		10
10a	Therapy										10a
11	Activities	105,816	22,728	33,726	162,270		162,270		162,270		11
12	Social Services	24,313		59,065	83,378		83,378		83,378		12
13	CNA Training										13
14	Program Transportation			7,449	7,449		7,449		7,449		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,967,107	65,676	1,240,980	4,273,763		4,273,763		4,273,763		16
	C. General Administration										
17	Administrative			709,578	709,578		709,578	(530,422)	179,156		17
18	Directors Fees										18
19	Professional Services			53,847	53,847		53,847	(8,243)	45,604		19
20	Dues, Fees, Subscriptions & Promotions			19,476	19,476		19,476	(2,032)	17,444		20
21	Clerical & General Office Expenses	19,091	46,988	449,963	516,042		516,042	(240,110)	275,932		21
22	Employee Benefits & Payroll Taxes			570,803	570,803	68,255	639,058		639,058		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,396	1,396		1,396		1,396		24
25	Other Admin. Staff Transportation							4,814	4,814		25
26	Insurance-Prop.Liab.Malpractice			160,995	160,995		160,995	12,948	173,943		26
27	Other (specify):*							72,541	72,541		27
28	TOTAL General Administration	19,091	46,988	1,966,058	2,032,137	68,255	2,100,392	(690,504)	1,409,888		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,076,793	829,464	3,711,424	8,617,681		8,617,681	(680,656)	7,937,025		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 Manor Inc.

#0027870

Report Period Beginning:

01/01/11

Ending:

12/31/11

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 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			111,036	111,036		111,036	25,098	136,134			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							161,522	161,522			32
33	Real Estate Taxes			235,191	235,191		235,191	3,841	239,032			33
34	Rent-Facility & Grounds			240,000	240,000		240,000	(240,000)				34
35	Rent-Equipment & Vehicles			10,264	10,264		10,264		10,264			35
36	Other (specify):*											36
37	TOTAL Ownership			596,491	596,491		596,491	(49,539)	546,952			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	285,165	977,621	540,327	1,803,113		1,803,113		1,803,113			39
40	Barber and Beauty Shops			8	8		8		8			40
41	Coffee and Gift Shops			5,703	5,703		5,703	(360)	5,343			41
42	Provider Participation Fee			107,858	107,858		107,858		107,858			42
43	Other (specify):*			27,989	27,989		27,989	(27,989)	0			43
44	TOTAL Special Cost Centers	285,165	977,621	681,885	1,944,671		1,944,671	(28,349)	1,916,322			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,361,958	1,807,085	4,989,800	11,158,843		11,158,843	(758,544)	10,400,299			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 Manor Inc.

0027870

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	17,846	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	(298)	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	(6,124)	21		18
19	Entertainment	(1,200)	21		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	(380,624)	21		24
25	Fund Raising, Advertising and Promotional	(2,404)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(53)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(125,663)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (498,520)		\$	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)	(260,024)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (260,024)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (758,544)		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	

SEE ACCOUNTANTS' COMPILATION REPORT

St. Agnes Manor Inc.

ID# 0027870

Report Period Beginning: 01/01/11

Ending: 12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Additional R&M	\$ 10,184	06	1
2	Coke Machine Income	(360)	41	2
3	Bank Charges	(12,984)	21	3
4	Capitalized R&M	(3,355)	06	4
5	Building Co. - Management Fees	(72,000)	17	5
6	Building Co. - Licenses & Fees	(535)	20	6
7	Building Co.- Professional Fees	(2,279)	19	7
8	PPA - R&M	(3,084)	06	8
9	PPA - Fines	(670)	21	9
10	Annual Fee	(100)	20	10
11	Outside Labor - Marketing Director	(27,989)	43	11
12	Non-Allowable Legal	(12,491)	19	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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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	(125,663)		49

St. Agnes Manor Inc.

ID# 0027870

Report Period Beginning: 01/01/11

Ending: 12/31/11

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
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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 St. Agnes Manor Inc.# 0027870

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	(298)											(298)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			2,269									2,269	5
6	Maintenance	3,745		4,132									7,877	6
7	Other (specify):*													7
8	TOTAL General Services	3,447		6,401									9,848	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative	(72,000)	72,000	(530,422)									(530,422)	17
18	Directors Fees													18
19	Professional Services	(14,770)	2,279	4,248									(8,243)	19
20	Fees, Subscriptions & Promotions	(3,039)	535	472									(2,032)	20
21	Clerical & General Office Expenses	(401,655)		161,545									(240,110)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation			4,814									4,814	25
26	Insurance-Prop.Liab.Malpractice			12,948									12,948	26
27	Other (specify):*			72,541									72,541	27
28	TOTAL General Administration	(491,464)	74,814	(273,854)									(690,504)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(488,017)	74,814	(267,453)									(680,656)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St. Agnes Manor Inc.# 0027870

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	17,846		7,252									25,098	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		155,351	6,171									161,522	32
33	Real Estate Taxes			3,841									3,841	33
34	Rent-Facility & Grounds		(240,000)										(240,000)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	17,846	(84,649)	17,264									(49,539)	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	(360)											(360)	41
42	Provider Participation Fee													42
43	Other (specify):*	(27,989)											(27,989)	43
44	TOTAL Special Cost Centers	(28,349)											(28,349)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(498,520)	(9,835)	(250,189)									(758,544)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 6-Supplemental		See 6-Supplemental		See 6-Supplemental		
				1721 Corp	Chicago Il	Building Co.

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 Rental Income	\$ 240,000	1721 Corp	100.00%	\$		(240,000) 1
2	V	32 Interest Expense		1721 Corp	100.00%	155,351		155,351 2
3	V	17 Management Fees		1721 Corp	100.00%	72,000		72,000 3
4	V	20 Licenses & Fees		1721 Corp	100.00%	535		535 4
5	V	19 Professional Fees		1721 Corp	100.00%	2,279		2,279 5
6	V							
7	V							
8	V							
9	V							
10	V							
11	V							
12	V							
13	V							
14	Total		\$ 240,000			\$ 230,165	\$ *	(9,835) 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%	\$ 2,269	\$ 2,269
16	V	6 REPAIRS AND MAINT.		MADO MGMT. LP	100.00%	4,132	4,132
17	V	17 ADMINISTRATIVE		MADO MGMT. LP	100.00%	7,578	7,578
18	V	19 PROFESSIONAL FEES		MADO MGMT. LP	100.00%	4,248	4,248
19	V	20 DUES AND SUBSCRIPTIONS		MADO MGMT. LP	100.00%	472	472
20	V	21 CLERICAL AND GENERAL		MADO MGMT. LP	100.00%	161,545	161,545
21	V	25 AUTO EXPENSE		MADO MGMT. LP	100.00%	4,814	4,814
22	V	26 PROPERTY INSURANCE		MADO MGMT. LP	100.00%	12,948	12,948
23	V	27 GEN. ADMIN. - EMP. BEN.		MADO MGMT. LP	100.00%	38,293	38,293
24	V	30 DEPRECIATION		MADO MGMT. LP	100.00%	7,252	7,252
25	V	32 INTEREST		MADO MGMT. LP	100.00%	6,171	6,171
26	V	33 REAL ESTATE TAXES		MADO MGMT. LP	100.00%	3,841	3,841
27	V						
28	V	17 MANAGEMENT FEES	660,000	MADO MGMT. LP	100.00%		(660,000)
29	V						
30	V	17 SALARY-P. O'BRIEN		MADO MGMT. LP	100.00%	44,287	
31	V	27 EMP. BEN.-P. O'BRIEN		MADO MGMT. LP	100.00%	7,392	7,392
32	V						
33	V				100.00%		
34	V	17 ADMINISTRATIVE SALARY		MADO MGMT. LP	100.00%	122,000	122,000
35	V	27 GEN. ADMIN. - EMP. BEN.		MADO MGMT. LP	100.00%	26,856	26,856
36	V	33 REAL ESTATE TAXES		MADO MGMT. LP	100.00%		
37	V						
38	V						
39	Total		\$ 660,000			\$ 454,098	\$ * (250,189)

* 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	\$ 891,199	WINDY CITY NURSING	100.00%	\$ 891,199	\$	15
16	V	39 THERAPY	303,980	WINDY CITY NURSING	100.00%	303,980		16
17	V	01 DIETARY	109,193	WINDY CITY NURSING	100.00%	109,193		17
18	V	11 ACTIVITY	31,570	WINDY CITY NURSING	100.00%	31,570		18
19	V	21 CLERICAL	104,475	WINDY CITY NURSING	100.00%	104,475		19
20	V	06 MAINTENANCE	38,200	WINDY CITY NURSING	100.00%	38,200		20
21	V	12 SOCIAL SERVICES	55,648	WINDY CITY NURSING	100.00%	55,648		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		\$ 1,534,265			\$ 1,534,265	\$ *	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: 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.

Facility Name & ID Number

St. Agnes Manor Inc.

0027870

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

Facility Name & ID Number

St. Agnes Manor Inc.

0027870

Report Period Beginning:

01/01/11

Ending:

12/31/11

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.

Facility Name & ID Number St. Agnes Manor Inc.

0027870

Report Period Beginning: 01/01/11

Ending: 12/31/11

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.

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.

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.

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.

Facility Name & ID Number

St. Agnes Manor Inc.

0027870

Report Period Beginning:

01/01/11

Ending:

12/31/11

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	DANIEL O'BRIEN	20.000%	MARGARET MANOR, INC.	CHICAGO	1721 CORP.	CHICAGO	BUILDING CO.	1
2	MARY O'BRIEN	20.000%	NINE FORTY COLLOM CORPORATION □ D/B/A MARGARET MANOR	CHICAGO	WINDY CITY NURSING (CONT.)	CHICAGO	NURSING, DIETARY, AC	2
3	PETER O'BRIEN	60.000%	SACRED HEART HOME INCORPORATED	CHICAGO	MADO MANAGEMENT	CHICAGO	BOOKEEPING / MANAGE	3
4			FORTY SIX TWENTY ONE CORPORATION INCORPORATED □ D/B/A	CHICAGO	WINDY CITY NURSING	CHICAGO	OUTSIDE LABOR FOR:	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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

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

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

Facility Name & ID Number St. Agnes Manor Inc. # 0027870 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	11.3	18.83%	Alloc. Salary	\$ 44,287	17-07	1
2											2
3											3
4											4
5											5
6											6
7	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts anticipated to be considered allowable										7
8	by the Il. Dept of HFS.										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 44,287		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 Manor Inc.

0027870

Report Period Beginning:

01/01/11

Ending: 12/31/11

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 Manor Inc.

0027870

Report Period Beginning:

01/01/11

Ending: 12/31/11

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	224,804	5	\$ 9,221	\$ 55,311	\$ 2,269	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	224,804	5	16,792	55,311	4,132	2
3	17	ADMINISTRATIVE	PATIENT DAYS	224,804	5	30,800	30,800	7,578	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	224,804	5	17,267	55,311	4,248	4
5	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	224,804	5	1,919	55,311	472	5
6	21	CLERICAL AND GENERAL	PATIENT DAYS	224,804	5	656,578	593,075	161,545	6
7	25	AUTO EXPENSE	PATIENT DAYS	224,804	5	19,564	55,311	4,814	7
8	26	PROPERTY INSURANCE	PATIENT DAYS	224,804	5	52,624	55,311	12,948	8
9	27	GEN. ADMIN. - EMP. BEN.	PATIENT DAYS	224,804	5	155,635	55,311	38,293	9
10	30	DEPRECIATION	PATIENT DAYS	224,804	5	29,474	55,311	7,252	10
11	32	INTEREST	PATIENT DAYS	224,804	5	25,083	55,311	6,171	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	224,804	5	15,609	55,311	3,841	12
13									13
14									14
15									15
16	17	SALARY-P. O'BRIEN	AVG. HOURS WORKED	46	5	180,000	180,000	44,287	16
17	27	EMP. BEN.-P. O'BRIEN	AVG. HOURS WORKED	46	5	30,045	11	7,392	17
18									18
19									19
20	17	ADMINISTRATIVE SALARY	DIRECT ALLOCATION		5	512,073	512,073	122,000	20
21	27	GEN. ADMIN. - EMP. BEN.	DIRECT ALLOCATION		5	89,705		26,856	21
22	33	REAL ESTATE TAXES	DIRECT ALLOCATION		1	4,375			22
23									23
24									24
25	TOTALS					\$ 1,846,764	\$ 1,315,948	\$ 454,098	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Agnes Manor Inc.

0027870

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Windy City Nursing

Street Address

1541 N. Wells Street

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	10	NURSING	DIRECT ALLOCATION		\$	\$		\$ 891,199	1
2	39	THERAPY	DIRECT ALLOCATION					303,980	2
3	1	DIETARY	DIRECT ALLOCATION					109,193	3
4	11	ACTIVITY	DIRECT ALLOCATION					31,570	4
5	21	CLERICAL	DIRECT ALLOCATION					104,475	5
6	6	MAINTENANCE	DIRECT ALLOCATION					38,200	6
7	12	SOCIAL SERVICES	DIRECT ALLOCATION					55,648	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				\$	\$		\$ 1,534,265	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Agnes Manor Inc.

0027870

Report Period Beginning:

01/01/11

Ending: 12/31/11

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 Manor Inc.

0027870

Report Period Beginning:

01/01/11

Ending: 12/31/11

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 Manor Inc.

0027870

Report Period Beginning:

01/01/11

Ending: 12/31/11

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 Manor Inc.

0027870

Report Period Beginning:

01/01/11

Ending: 12/31/11

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 Manor Inc.

0027870

Report Period Beginning:

01/01/11

Ending: 12/31/11

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 Manor Inc.

0027870 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Manor Inc.

0027870

Report Period Beginning:

01/01/11

Ending: 12/31/11

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 Manor Inc.

0027870

Report Period Beginning:

01/01/11

Ending:

12/31/11

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		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.)

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St. Agnes Manor Inc. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0027870

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number St. Agnes Manor Inc.

0027870

Report Period Beginning:

01/01/11

Ending:

12/31/11

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:

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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	Facility			1983	\$ 424,750	\$	35	\$	\$	\$ 424,750	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			63,352	13
14	Various			1990	150,700		20	360	360	132,436	14
15	Various			1991	37,665		20	586	586	34,389	15
16	Various			1992	45,688		20	2,284	2,284	36,594	16
17	Various			1993	56,127		20	2,806	2,806	47,045	17
18	Various			1994	133,605		20	6,680	6,680	109,953	18
19	Various			1995	110,000		20	7,627	7,627	127,246	19
20	Various			1996	173,235		20	9,125	9,125	140,462	20
21	Various			1997	219,118		20	11,582	11,582	167,721	21
22	Various			1998	314,520		20	15,687	15,687	212,641	22
23	Various			1999	387,533		20	19,377	19,377	232,529	23
24	Various			2000	69,634		20	3,482	3,482	38,592	24
25	Various			2001	107,788		20	5,389	5,389	57,308	25
26	Various			2002	44,685		20	2,552	2,552	29,154	26
27	Various			2003	12,389		20	846	846	9,046	27
28	Various			2004	50,665		20	4,923	4,923	36,480	28
29	Various			2005	57,918		20	3,029	3,029	21,243	29
30	Various			2006	25,274		20	2,634	2,634	14,552	30
31	Various			2007	35,883		20	3,221	3,221	14,275	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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	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		78,306	2,385		2,902	517	46,474	68
69			111,036			(111,036)		69
70		\$ 4,172,274	\$ 113,421		\$ 105,093	\$ (8,328)	\$ 3,493,287	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 Manor Inc.

0027870

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,172,274	\$ 113,421		\$ 105,093	\$ (8,328)	\$ 3,493,287	1
2	Elevator Interface Control Board	2008	2,048		20	102	102	410	2
3	Wall Fans & Installation	2008	4,448		20	222	222	741	3
4	Exterior Light Fixtures	2008	6,485		20	324	324	1,189	4
5	Rewire 15 Fire Alarms	2008	2,648		20	132	132	485	5
6	Hot Water Circulating Pump	2008	2,185		20	109	109	391	6
7	Courtyard Door	2008	5,075		20	254	254	888	7
8	Fire Alarm System Upgrade	2008	4,040		20	202	202	673	8
9	2 Boilers (Net Of Reimb)	2008	3,270		20	164	164	545	9
10	Rewired 70 Ton Air Conditioner	2008	8,105		20	405	405	1,317	10
11	Upgraded / Replaced Sprinklers	2008	2,521		20	126	126	420	11
12	Elevator Repair	2008	3,848		20	192	192	593	12
13	Tuckpointing	2008	3,200		20	160	160	533	13
14	Caulking	2008	8,400		20	420	420	1,400	14
15	Elevator - New Motor Drive	2009	4,287		20	214	214	643	15
16	Generator - Monitoring Meter	2009	2,758		20	138	138	356	16
17	Disconnect, Repair, & Reinstall Fire Pressure Pump	2009	5,130		20	257	257	684	17
18	Upgrade Cpu/Software In Elevator	2009	4,136		20	207	207	551	18
19	Fire Sprinkler Repairs From Pipe Breaking	2009	6,384		20	319	319	958	19
20	New Water Heater	2010	5,225		20	261	261	283	20
21	Centralize A/C System In Annex Building	2010	8,215		20	411	411	650	21
22	Exhaust Assembly	2010	5,285		20	264	264	396	22
23	Repair Fire Sprinkler System	2010	2,725		20	136	136	204	23
24	Grinding & Tuckpointing - East & Southwest Walls	2010	6,700		20	335	335	503	24
25	Replaced Smoke Detectors & Fire Alarm System	2011	6,261		20	313	313	313	25
26	12 1/2 Ton Cooling 224,000 Btu Gas Heating Unit	2011	15,965		20	665	665	665	26
27	New Car Top Selector On Elevator	2011	4,160		20	156	156	156	27
28	Remodel 3Rd Floor-Tile, Counters, Sinks, Cabinets, Walls, Paintin	2011	19,859		20	414	414	414	28
29	Repair 3 A/C Units In The Courtyard, Alley And Roof Top	2011	3,355		20	336	336	336	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,328,990	\$ 113,421		\$ 112,332	\$ (1,089)	\$ 3,509,986	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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,328,990	\$ 113,421		\$ 112,332	\$ (1,089)	\$ 3,509,986	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)	\$ 4,328,990	\$ 113,421		\$ 112,332	\$ (1,089)	\$ 3,509,986	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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,328,990	\$ 113,421		\$ 112,332	\$ (1,089)	\$ 3,509,986	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)	\$ 4,328,990	\$ 113,421		\$ 112,332	\$ (1,089)	\$ 3,509,986	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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,328,990	\$ 113,421		\$ 112,332	\$ (1,089)	\$ 3,509,986	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)	\$ 4,328,990	\$ 113,421		\$ 112,332	\$ (1,089)	\$ 3,509,986	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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$	\$		\$	\$	\$	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 (12F & 12G lines 1 thru 33)	\$	\$		\$	\$	\$	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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Related Party Information		\$	\$		\$	\$		1
2	Buildings:								2
3	Allocated from MADO Management	1988	50,998	1,862	35	1,457	(405)	23,313	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from MADO Management	1995	1,183		20	59	59	976	9
10	Allocated from MADO Management	1993	19,425	517	20	971	454	17,895	10
11	Allocated from MADO Management	2000	2,905		20	145	145	1,674	11
12	Allocated from MADO Management	2001	1,258		20	63	63	675	12
13	Allocated from MADO Management	2002	1,980		20	179	179	1,738	13
14	Allocated from MADO Management	2004	557	6	20	28	22	203	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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1								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)	\$ 78,306	\$ 2,385		\$ 2,902	\$ 517	\$ 46,474	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 Manor Inc.

0027870

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 178,073	\$ 165	\$ 9,836	\$ 9,671	10	\$ 139,514	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	170,273		177	177	10	167,383	73
74								74
75	TOTALS	\$ 348,346	\$ 165	\$ 10,013	\$ 9,848		\$ 306,897	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1995 JEEP LAREDO	1995	\$ 25,368	\$	\$	\$	5	\$ 18,321	76
77		2009 NISSAN MURANO	2008	33,984		6,797	6,797	5	23,223	77
78		Allocated from MADO Managem	2010	53,699	4,700	6,990	2,290	5	38,007	78
79										79
80	TOTALS			\$ 113,051	\$ 4,700	\$ 13,787	\$ 9,087		\$ 79,551	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)	\$ 4,865,637	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 118,286	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 136,132	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 17,846	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,896,434	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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: \$ 10,264 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. _____ /2012 \$ _____

13. _____ /2013 \$ _____

14. _____ /2014 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	Cost			Units	Cost								
1	Licensed Occupational Therapist	39 - 01	hrs	\$ 53,525		\$ 17,764							\$ 71,289		1	
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	3,393		94,160							97,553		2	
3	Licensed Recreational Therapist		hrs												3	
4	Licensed Physical Therapist	39 - 01	hrs	21,625		69,604							91,229		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							382,532			382,532		9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs												10	
11	Academic Education		hrs												11	
12	Other (specify): _____	39 - 02								200,151			200,151		12	
13	Other (specify): <u>See Supplemental</u>			206,622		358,799				394,938			960,359		13	
14	TOTAL			\$ 285,165		\$ 540,327				\$ 977,621			\$ 1,803,113		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 Manor Inc.# 0027870Report Period Beginning: 01/01/11Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/11

(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	\$ 45,206	\$ 48,218	1
2	Cash-Patient Deposits	809	809	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,209,155	2,209,155	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,072	14,072	6
7	Other Prepaid Expenses	2,747	2,747	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	1,373	19,312	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,273,362	\$ 2,294,313	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	1,891,556	2,845,089	15
16	Equipment, at Historical Cost	324,108	331,401	16
17	Accumulated Depreciation (book methods)	(1,204,200)	(3,905,959)	17
18	Deferred Charges		1,288,774	18
19	Organization & Pre-Operating Costs		49,987	19
20	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>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,011,464	\$ 1,088,114	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,284,826	\$ 3,382,427	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 2,357,417	\$ 2,357,418	26
27	Officer's Accounts Payable	2,089,924	2,089,924	27
28	Accounts Payable-Patient Deposits	11,663	11,663	28
29	Short-Term Notes Payable		2,300,841	29
30	Accrued Salaries Payable	157,026	157,026	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,808	1,808	31
32	Accrued Real Estate Taxes(Sch.IX-B)	236,579	236,579	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	842	842	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,855,259	\$ 7,156,101	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>	2,402,549	646,322	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,402,549	\$ 646,322	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,257,808	\$ 7,802,423	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,972,982)	\$ (4,419,996)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,284,826	\$ 3,382,427	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,714,313)	1
2	Restatements (describe):		2
3	Late Entries	(27,822)	3
4	Rounding Error	1	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,742,134)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(230,848)	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)	\$ (230,848)	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)	\$ (3,972,982)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Agnes Manor Inc.# 0027870Report Period Beginning: 01/01/11Ending: 12/31/11

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	\$ 8,718,031	1
2	Discounts and Allowances for all Levels	(550,096)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,167,935	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	879,065	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 879,065	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	417,715	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,364	19
20	Radiology and X-Ray	8,054	20
21	Other Medical Services	978,111	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,424,244	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	<u>See Supplemental Schedule</u>	456,751	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 456,751	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,927,995	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,311,781	31
32	Health Care	4,273,763	32
33	General Administration	2,032,137	33
B. Capital Expense			
34	Ownership	596,491	34
C. Ancillary Expense			
35	Special Cost Centers	1,836,813	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)*	\$ 11,158,843	40
41	Income before Income Taxes (line 30 minus line 40)**	(230,848)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (230,848)	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 Manor Inc.

0027870

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	
2	Assistant Director of Nursing				2	
3	Registered Nurses	8,156	8,323	208,464	25.05	3
4	Licensed Practical Nurses	35,078	36,237	921,028	25.42	4
5	CNAs & Orderlies	143,681	153,947	1,707,486	11.09	5
6	CNA Trainees					6
7	Licensed Therapist	10,507	10,784	285,165	26.44	7
8	Rehab/Therapy Aides					8
9	Activity Director	3,897	4,252	47,399	11.15	9
10	Activity Assistants	5,030	5,833	58,417	10.01	10
11	Social Service Workers	1,338	1,354	24,313	17.96	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	10,149	11,027	126,535	11.48	14
15	Cook Helpers/Assistants	27,578	30,783	332,433	10.80	15
16	Dishwashers	109	109	1,006	9.23	16
17	Maintenance Workers	19,315	21,030	201,832	9.60	17
18	Housekeepers	28,085	30,633	288,894	9.43	18
19	Laundry	13,245	14,911	139,895	9.38	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,816	2,115	19,091	9.03	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	307,984	331,338	\$ 4,361,958 *	\$ 13.16	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	\$		35	
36	Medical Director			36	
37	Medical Records Consultant	88	4,136	10-03	37
38	Nurse Consultant	668	38,307	10-03	38
39	Pharmacist Consultant	25	4,175	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	44	2,156	11-03	44
45	Social Service Consultant	2,976	59,065	12-03	45
46	Other(specify)				46
47	<u>Outside Labor- Dietary Consultant</u>	3,668	109,193	01-03	47
48	<u>Outside Labor-Activity Consultant</u>	2,049	31,570	11-03	48
49	TOTAL (lines 35 - 48)	9,518	\$ 248,602		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	10,520	\$ 370,386	10-03	50
51	Licensed Practical Nurses	22,521	723,736	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	33,041	\$ 1,094,122		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Agnes Manor Inc.

0027870

Report Period Beginning: 01/01/11

Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function				Description	Amount	Description	Amount		
				Workers' Compensation Insurance	\$ 228,145	IDPH License Fee	\$ 3,980			
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	6,002			
				FICA Taxes	333,690	Health Care Worker Background Check	4,700			
				Employee Health Insurance	15,372	(Indicate # of checks performed <u>454</u>)				
				Employee Meals	68,255	Patient Background Checks				
				Illinois Municipal Retirement Fund (IMRF)*		Licenses, Dues & Fees	2,290			
				401K - Employers	9,058	Allocated from MAD0 Mgmt	472			
				Other Employee Welfare	481					
				Prior Period ADJ	(15,943)					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$						
B. Administrative - Other										
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)			
MADO Management			\$ 660,000	\$ 639,058			\$ 17,444			
Outside Labor - Assistant Administrator			49,578				Less: Public Relations Expense ()			
							Non-allowable advertising ()			
							Yellow page advertising ()			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 709,578						
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	\$ 9,000				Out-of-State Travel	\$			
Personnel Planners	Unemployment Consulting	3,414								
Wolf & Company, LLP	Accounting	4,847								
HDSI	Data Processing	13,647				In-State Travel				
See Attached	Legal	22,939								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 53,847	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)	
									\$ 1,396	

* 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	FY2007	FY2008	FY2009	FY2010
1	N/A			\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS			\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Agnes Manor Inc.# 0027870Report Period Beginning: 01/01/11Ending: 12/31/11**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? 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? 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. \$ 43,141 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. \$ 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? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (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. \$ 68,255 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?
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. \$ No
- (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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT