



Facility Name & ID Number Margaret Manor

# 0011239 Report Period Beginning: 01/01/13 Ending: 12/31/13

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	135	Intermediate (ICF)	135	49,275	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	135	TOTALS	135	49,275	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	3 Private Pay	4 Other	4 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	37,175	984	1,956	40,115	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,175	984	1,956	40,115	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.41%

D. How many bed-hold days during this year were paid by the Department? 0 (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 07/1/1969

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

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Margaret Manor

# 0011239

Report Period Beginning:

01/01/13

Ending:

12/31/13

**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
	<b>A. General Services</b>										
1	Dietary	213,948	24,315	37,619	275,882		275,882	275,882			1
2	Food Purchase		371,232		371,232	(44,548)	326,684	(857)	325,827		2
3	Housekeeping	136,734	54,858		191,592		191,592		191,592		3
4	Laundry	38,533	26,051		64,584		64,584		64,584		4
5	Heat and Other Utilities			72,532	72,532		72,532	2,527	75,059		5
6	Maintenance	96,812		137,464	234,276		234,276	1,842	236,118		6
7	Other (specify):* Security	119,832			119,832		119,832		119,832		7
8	<b>TOTAL General Services</b>	<b>605,859</b>	<b>476,456</b>	<b>247,615</b>	<b>1,329,930</b>	<b>(44,548)</b>	<b>1,285,382</b>	<b>3,512</b>	<b>1,288,894</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	880,955	42,568	324,836	1,248,359		1,248,359		1,248,359		10
10a	Therapy										10a
11	Activities	119,295	17,631		136,926		136,926		136,926		11
12	Social Services	121,140	2,958	107,395	231,493		231,493		231,493		12
13	CNA Training										13
14	Program Transportation			1,211	1,211		1,211		1,211		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,121,390</b>	<b>63,157</b>	<b>439,442</b>	<b>1,623,989</b>		<b>1,623,989</b>		<b>1,623,989</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative			546,000	546,000		546,000	(429,906)	116,094		17
18	Directors Fees										18
19	Professional Services			50,363	50,363	(19,170)	31,193	6,812	38,005		19
20	Dues, Fees, Subscriptions & Promotions			21,871	21,871		21,871	329	22,200		20
21	Clerical & General Office Expenses	32,014	13,155	195,907	241,076		241,076	53,188	294,264		21
22	Employee Benefits & Payroll Taxes			208,295	208,295	44,548	252,843		252,843		22
23	Inservice Training & Education										23
24	Travel and Seminar			175	175		175		175		24
25	Other Admin. Staff Transportation							8,310	8,310		25
26	Insurance-Prop.Liab.Malpractice			166,360	166,360		166,360		166,360		26
27	Other (specify):*							35,313	35,313		27
28	<b>TOTAL General Administration</b>	<b>32,014</b>	<b>13,155</b>	<b>1,188,971</b>	<b>1,234,140</b>	<b>25,378</b>	<b>1,259,518</b>	<b>(325,954)</b>	<b>933,564</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,759,263</b>	<b>552,768</b>	<b>1,876,028</b>	<b>4,188,059</b>	<b>(19,170)</b>	<b>4,168,889</b>	<b>(322,442)</b>	<b>3,846,447</b>		<b>29</b>

\*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.

Margaret Manor Inc.  
11239  
Cost Report Reclassifications  
01/01/13  
12/31/13

Schedule V  
Line #

22	Employee Benefits	<u>44,548</u>	
2	Food		<u>44,548</u>

*To reclass cost of employee meals from raw food to employee benefits*

33	Real Estate Tax	<u>19,170</u>	
19	Professional Fees		<u>19,170</u>

*To reclass cost of appealing real estate taxes*

Facility Name & ID Number Margaret Manor

#0011239

Report Period Beginning:

01/01/13

Ending:

12/31/13

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	<b>D. Ownership</b>											
30	Depreciation			53,296	53,296		53,296	50,269	103,565			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			256,730	256,730		256,730	26,803	283,533			32
33	Real Estate Taxes			112	112	19,170	19,282	129,263	148,545			33
34	Rent-Facility & Grounds			300,000	300,000		300,000	(300,000)				34
35	Rent-Equipment & Vehicles			4,919	4,919		4,919		4,919			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			615,057	615,057	19,170	634,227	(93,665)	540,562			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			906	906		906		906			40
41	Coffee and Gift Shops			7,601	7,601		7,601	(7,615)	(14)			41
42	Provider Participation Fee			183,771	183,771		183,771		183,771			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			192,278	192,278		192,278	(7,615)	184,663			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,759,263	552,768	2,683,363	4,995,394		4,995,394	(423,722)	4,571,672			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 Margaret Manor

# 0011239

Report Period Beginning: 01/01/13

Ending: 12/31/13

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	47,458	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	(857)	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	(50,094)	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	(17,722)	21		24
25	Fund Raising, Advertising and Promotional	(577)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(124,917)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (146,709)		\$	30

<b>BHF USE ONLY</b>					
48		49		50	51
					52

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(302,081)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (302,081)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (448,790)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

SEE ACCOUNTANTS' COMPILATION REPORT

Margaret Manor

ID# 0011239

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Coke Machine Revenue	\$ (7,615)	41	1
2	Bank Charges	(3,475)	21	2
3	Land Trust Fee	(320)	20	3
4	Annual Report	(100)	20	4
5	RE Tax 2011 Penalties & Publication Cost	(23,407)	33	5
6	Building Co - Management Fee	(90,000)	17	6
7	Late Fees	(364)	32	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		(125,281)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Margaret Manor# 0011239

Report Period Beginning:

01/01/13

Ending:

12/31/13

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(857)	0	0	0	0	0	0	0	0	0	0	(857)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,527	0	0	0	0	0	0	0	0	2,527	5
6	Maintenance	0	0	1,842	0	0	0	0	0	0	0	0	1,842	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(857)</b>	<b>0</b>	<b>4,369</b>	<b>0</b>	<b>3,512</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(90,000)	90,000	(429,906)	0	0	0	0	0	0	0	0	(429,906)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	6,812	0	0	0	0	0	0	0	0	6,812	19
20	Fees, Subscriptions & Promotions	(997)	1,113	213	0	0	0	0	0	0	0	0	329	20
21	Clerical & General Office Expenses	(71,291)	38	124,441	0	0	0	0	0	0	0	0	53,188	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	8,310	0	0	0	0	0	0	0	0	8,310	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	35,313	0	0	0	0	0	0	0	0	35,313	27
28	<b>TOTAL General Administration</b>	<b>(162,288)</b>	<b>91,151</b>	<b>(254,817)</b>	<b>0</b>	<b>(325,954)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(163,145)</b>	<b>91,151</b>	<b>(250,448)</b>	<b>0</b>	<b>(322,442)</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Margaret Manor# 0011239

Report Period Beginning:

01/01/13

Ending:

12/31/13

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	47,458	0	2,811	0	0	0	0	0	0	0	0	50,269	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(364)	22,447	4,720	0	0	0	0	0	0	0	0	26,803	32
33	Real Estate Taxes	(23,407)	146,537	6,133	0	0	0	0	0	0	0	0	129,263	33
34	Rent-Facility & Grounds	0	(300,000)	0	0	0	0	0	0	0	0	0	(300,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>23,687</b>	<b>(131,016)</b>	<b>13,664</b>	<b>0</b>	<b>(93,665)</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(7,615)	0	0	0	0	0	0	0	0	0	0	(7,615)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>(7,615)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(7,615)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(147,073)	(39,865)	(236,784)	0	0	0	0	0	0	0	0	(423,722)	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

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	\$ 300,000	Long Term Care LP	100.00%	\$	\$ (300,000)	1
2	V	33 Real Estate Taxes		Long Term Care LP	100.00%	146,537	146,537	2
3	V	17 Management Fee		Long Term Care LP	100.00%	90,000	90,000	3
4	V	32 Interest		Long Term Care LP	100.00%	22,447	22,447	4
5	V	20 Licenses & Fees		Long Term Care LP	100.00%	1,113	1,113	5
6	V	21 Penalty & Bank Charges		Long Term Care LP	100.00%	38	38	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	<b>Total</b>		\$ 300,000			\$ 260,135	\$ * (39,865)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Margaret Manor# 0011239Report Period Beginning: 01/01/13Ending: 12/31/13

## 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%	\$ 2,527	\$ 2,527
16	V	6 REPAIRS AND MAINTENANCE		MADO MGMT.LP	100.00%	1,842	1,842
17	V	17 ADMINISTRATIVE		MADO MGMT.LP	100.00%	0	
18	V	19 PROFESSIONAL FEES		MADO MGMT.LP	100.00%	6,812	6,812
19	V	20 DUES AND SUBSCRIPTIONS		MADO MGMT.LP	100.00%	213	213
20	V	21 CLERICAL AND GENERAL		MADO MGMT.LP	100.00%	124,441	124,441
21	V	25 AUTO EXPENSE		MADO MGMT.LP	100.00%	8,310	8,310
22	V	26 PROPERTY INSURANCE		MADO MGMT.LP	100.00%	0	
23	V	27 GEN.ADMIN.-EMP.BEN		MADO MGMT.LP	100.00%	24,407	24,407
24	V	30 DEPRECIATION		MADO MGMT.LP	100.00%	2,811	2,811
25	V	32 INTEREST		MADO MGMT.LP	100.00%	4,720	4,720
26	V	33 REAL ESTATE TAXES		MADO MGMT.LP	100.00%	3,066	3,066
27	V						
28	V	17 MANAGEMENT FEES	546,000	MADO MGMT.LP	100.00%		(546,000)
29	V						
30	V	17 SALARY-P.O'BRIEN		MADO MGMT.LP	100.00%	31,896	31,896
31	V	27 EMP. BEN P.O'BRIEN		MADO MGMT.LP	100.00%	4,090	4,090
32	V						
33	V						
34	V	17 ADMINISTRATIVE SALARY		MADO MGMT.LP	100.00%	84,198	84,198
35	V	27 GEN.ADMIN.-EMP.BEN.		MADO MGMT.LP	100.00%	6,816	6,816
36	V	33 REAL ESTATE TAXES		MADO MGMT.LP	100.00%	3,067	3,067
37	V						
38	V						
39	Total		\$ 546,000			\$ 309,216	\$ * (236,784)

\* 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	10 NURSING	\$ 318,832	WINDY CITY NURSING	100.00%	\$ 318,832	\$
16	V	01 DIETARY	37,619	WINDY CITY NURSING	100.00%	37,619	
17	V	21 CLERICAL	105,842	WINDY CITY NURSING	100.00%	105,842	
18	V	06 MAINTENANCE	50,078	WINDY CITY NURSING	100.00%	50,078	
19	V	12 SOCIAL SERVICE	99,492	WINDY CITY NURSING	100.00%	99,492	
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 611,863			\$ 611,863	\$ *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Margaret Manor

# 0011239

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	PETER O'BRIEN	100	ST. MARTHA MANOR	CHICAGO	LONG TERM CARE	CHICAGO	BUILDING CO	1
2			MARGARET MANOR NORTH	CHICAGO	WINDY CITY NURSI	CHICAGO	OUTSIDE LABOR	2
3			SACRED HEART HOME	CHICAGO	WINDY CITY NURSI	CHICAGO	NURSING & DIET	3
4			ST. AGNES MANOR INC.	CHICAGO	MADO MANAGEME	CHICAGO	BOOKEEPING/MA	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

Facility Name & ID Number Margaret Manor # 0011239 Report Period Beginning: 01/01/13 Ending: 12/31/13

## 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	100.00	144,706	9	15.00	Alloc.Salary	\$ 31,896	17-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 31,896		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

Peter O'Brien  
 Weighted Average Hours Worked  
 And Compensation  
 1/1/13 - 12/31/13

Facility Name	% Allocation	Average Hours Worked	Allocated Salary from MADO Mgmt	Total Compensation
Margaret Manor	17.72%	8.2	\$ 31,896	\$ 31,896
Margaret Manor North	14.75%	6.8	\$ 26,550	26,550
St. Agnes	24.75%	11.4	\$ 44,550	44,550
Sacred Heart	22.92%	10.5	\$ 41,256	41,256
St. Martha	19.86%	9.1	\$ 35,748	35,748
Other	-	14.0	-	-
<b>Total</b>	<b>100.00%</b>	<b>60.0</b>	<b>\$ 180,000</b>	<b>\$ 180,000</b>

Facility Name & ID Number Margaret Manor

# 0011239

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 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

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	5	UTILITIES	PATIENT DAYS	226,409	5	\$ 14,262	\$ 40,115	\$ 2,527	1	
2	6	REPAIRS & MAINT.	PATIENT DAYS	226,409	5	10,399	40,115	1,842	2	
3	17	ADMINISTRATIVE	PATIENT DAYS	226,409	5		40,115	0	3	
4	19	PROFESSIONAL FEES	PATIENT DAYS	226,409	5	38,446	40,115	6,812	4	
5	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	226,409	5	1,203	40,115	213	5	
6	21	CLERICAL & GENERAL	PATIENT DAYS	226,409	5	702,342	40,115	124,441	6	
7	25	AUTO EXPENSE	PATIENT DAYS	226,409	5	46,904	40,115	8,310	7	
8	26	PROPERTY INSURANCE	PATIENT DAYS	226,409	5		40,115	0	8	
9	27	GEN.ADMINS -EMP.BEN.	PATIENT DAYS	226,409	5	137,755	40,115	24,407	9	
10	30	DEPRECIATION	PATIENT DAYS	226,409	5	15,864	40,115	2,811	10	
11	32	INTEREST	PATIENT DAYS	226,409	5	26,640	40,115	4,720	11	
12	33	REAL ESTATE TAXES	PATIENT DAYS	226,409	5	17,306	40,115	3,066	12	
13									13	
14									14	
15									15	
16	17	SALARY-P. O'BRIEN	AVG. HOURS WORKED	60	5	180,000	180,000	8	31,896	16
17	27	EMP.BEN.-P.O'BRIEN	AVG. HOURS WORKED	60	5	30,107		8	4,090	17
18									18	
19									19	
20	17	ADMINISTRATIVE SALARY	DIRECT ALLOCATION		5	647,415	647,415		84,198	20
21	27	GEN.ADMIN.-EMP.BEN.	DIRECT ALLOCATION		5	88,500			6,816	21
22	33	REAL ESTATE TAXES	DIRECT ALLOCATION		1	3,067			3,067	22
23									23	
24									24	
25	TOTALS					\$ 1,960,210	\$ 827,415	\$ 309,216	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Margaret Manor

# 0011239

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	Name of Lender	2		3	4	5	6		8	9	10	11						
		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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	North Community Bank		X	Mortgage	\$27,610.44	03/10/04	\$	\$	11/27/13	6.7500	\$ 253,841	1						
2	Allocated from related parties	X				11/27/13					65	2						
3	Allocated from LTC LP	X									22,447	3						
4												4						
5												5						
<b>Working Capital</b>																		
6	Allocated from MADO Manage	X									4,720	6						
7	Bridgeview Bank		X	Line of Credit							2,457	7						
8	Sacred Heart Home	X		Line of Credit							3	8						
9	<b>TOTAL Facility Related</b>				\$27,610.44		\$	\$			\$ 283,533	9						
<b>B. Non-Facility Related*</b>																		
10												10						
11												11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14						
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$ 283,533	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

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

SEE ACCOUNTANTS' COMPILATION REPORT

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



## 2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Margaret Manor COUNTY Cook  
 FACILITY IDPH LICENSE NUMBER 0011239  
 CONTACT PERSON REGARDING THIS REPORT Peter O'Brien  
 TELEPHONE 312 787-9400 FAX #: 312 787-345

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2012 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 2012.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>17-04-401-001-0000</u>	<u>Long Term Care Poperty</u>	\$ <u>22,543.66</u>	\$ <u>22,543.66</u>
2. <u>17-04-401-004-0000</u>	<u>Long Term Care Poperty</u>	\$ <u>5,636.79</u>	\$ <u>5,636.79</u>
3. <u>17-04-401-005-0000</u>	<u>Long Term Care Poperty</u>	\$ <u>5,857.46</u>	\$ <u>5,857.46</u>
4. <u>17-04-401-006-0000</u>	<u>Long Term Care Poperty</u>	\$ <u>6,220.88</u>	\$ <u>6,220.88</u>
5. <u>17-04-401-007-0000</u>	<u>Long Term Care Poperty</u>	\$ <u>6,654.01</u>	\$ <u>6,654.01</u>
6. <u>17-04-401-008-0000</u>	<u>Long Term Care Poperty</u>	\$ <u>2,916.00</u>	\$ <u>2,916.00</u>
7. <u>17-04-401-009-0000</u>	<u>Long Term Care Poperty</u>	\$ <u>3,230.04</u>	\$ <u>3,230.04</u>
8. <u>17-04-401-010-0000</u>	<u>Long Term Care Poperty</u>	\$ <u>11,075.44</u>	\$ <u>11,075.44</u>
9. <u>17-04-409-009-0000</u>	<u>Long Term Care Poperty</u>	\$ <u>57,191.82</u>	\$ <u>57,191.82</u>
10. <u>17-04-204-012-0000</u>	<u>Home Office Allocation</u>	\$ <u>25,450.20</u>	\$ <u>3,066.85</u>
<b>TOTALS</b>		\$ <u><u>146,776.30</u></u>	\$ <u><u>124,392.95</u></u>

**B. Real Estate Tax Cost Allocations**

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

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

C.    **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

**PLEASE NOTE:** *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Margaret Manor

# 0011239 Report Period Beginning:

01/01/13 Ending:

12/31/13

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 26,250 B. General Construction Type: Exterior Brick Frame Brick Number of Stories 5

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).

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>26,250</u>	<u>1962</u>	<u>\$ 2,000</u>	1
2					2
3	<b>TOTALS</b>	<b>26,250</b>		<b>\$ 2,000</b>	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				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9		1975		9,723		20			9,723	9
10		1976		6,706		20			6,706	10
11		1977		46,090		20			46,090	11
12		1978		21,593		20			21,593	12
13		1979		23,565		20			23,565	13
14		1982		4,014		20			3,981	14
15		1983		5,200		20			5,200	15
16		1984		4,952		20			4,344	16
17		1985		9,766		20			9,548	17
18		1986		36,773		20			30,774	18
19		1987		7,315		20			7,315	19
20		1988		6,455		20			6,455	20
21		1989		2,400		20			2,400	21
22		1990		7,500		20			6,209	22
23		1991		19,058		20			19,058	23
24		1992		103,932		20	4,764	4,764	108,267	24
25		1993		65,481		20	2,448	2,448	63,033	25
26		1994		115,474		20	5,774	5,774	112,586	26
27		1995		17,694		20	885	885	16,368	27
28		1996		90,906		20	4,545	4,545	79,145	28
29		1997		91,102		20	4,555	4,555	75,418	29
30		1998		74,085		20	3,704	3,704	56,968	30
31		1999		22,069		20	1,103	1,103	15,868	31
32		2000		53,714		20	2,686	2,686	36,601	32
33		2001		168,431		20	8,394	8,394	106,724	33
34		2002		143,928		20	2,173	2,173	143,928	34
35		2003		74,633		20	3,732	3,732	39,033	35
36		2004		137,143		20	1,374	1,374	120,273	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Margaret Manor

# 0011239

Report Period Beginning:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Various	2005	\$ 135,532	\$	20	\$ 8,425	\$ 8,425	\$ 71,205	37
38	Various	2006	124,264		20	12,377	12,377	90,768	38
39	Various	2007	37,298		20	4,387	4,387	31,857	39
40	Various	2008	130,611		20	6,531	6,531	35,698	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69	Financial Statement Depreciation			53,216			(53,216)		69
70	TOTAL (lines 4 thru 69)		\$ 1,797,407	\$ 53,216		\$ 77,857	\$ 24,641	\$ 1,406,701	70

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	Totals from Page 12A, Carried Forward		\$ 1,797,407	\$ 53,216		\$ 77,857	\$ 24,641	\$ 1,406,701	1
2	Gas Water Heater	2009	4,292		20	215	215	895	2
3	Grind Out Old Mortar	2009	72,900		20	3,645	3,645	18,225	3
4	Flooring & Shower Bases	2009	7,800		20	390	390	1,918	4
5	Resident Room Flooring	2009	5,154		20	258	258	1,203	5
6	2 Vacuum Condensate Tanks	2009	9,885		20	494	494	2,059	6
7	Asphalt Repairs	2010	4,427		20	221	221	940	7
8	Activity Room	2010	2,515		20	126	126	472	8
9	Intercom System Upgrade	2010	9,860		20	493	493	1,643	9
10	Install Fire Pump	2010	3,765		20	188	188	753	10
11	Elevator Motor Repair	2011	10,356		20	518	518	1,985	11
12	Hot Water Heater in Laundry Room	2011	4,677		20	234	234	663	12
13	Smoke Detectors-Resident Rooms	2011	12,900		20	645	645	1,935	13
14	Refurbished Gear Boxc for Elevator Machine	2011	10,280		20	514	514	1,242	14
15	Replacement of 33 Sprinkler Heads	2011	3,866		20	193	193	451	15
16	Tuckpointing of Roof-SW & ES Walls	2012	9,100		20	455	455	910	16
17	Furnished & Installed Pit Safety Switch & Wire	2012	2,514		20	126	126	252	17
18	Stone Retaining Wall-East Courtyard	2013	4,800		20	240	240	240	18
19	1st Floor Independent Living Unit	2013	72,576		20	3,629	3,629	3,629	19
20	Elevator Gate Operator	2013	3,659		20	183	183	183	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)		\$ 2,052,733	\$ 53,216		\$ 90,623	\$ 37,407	\$ 1,446,298	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	Totals from Page 12G, Carried Forward		\$ 2,052,733	\$ 53,216		\$ 90,623	\$ 37,407	\$ 1,446,298	1
2	Buildings:								2
3	Allocated From MADO Management	1988	40,642	1,484	35	1,161	(323)		3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from MADO Management	1995	943		20	47	47		9
10	Allocated From MADO Management	1993	15,480		20	774	774		10
11	Allocated From MADO Management	2000	2,315		20	116	116		11
12	Allocated From MADO Management	2001	1,003		20	50	50		12
13	Allocated From MADO Management	2002	1,578		20	79	79		13
14	Allocated From MADO Management	2004	444		20	22	22		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)		\$ 2,115,138	\$ 54,700		\$ 92,873	\$ 38,173	\$ 1,446,298	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 117,262	\$ 80	\$ 6,157	\$ 6,077	10	\$ 89,547	71
72	Current Year Purchases	3,278		164	164	10	164	72
73	Fully Depreciated Assets	253,136		223	223	10	250,890	73
74								74
75	TOTALS	\$ 373,676	\$ 80	\$ 6,544	\$ 6,464		\$ 340,601	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		86 OLDS	1990	\$	\$	\$	\$		\$ 5,000	76
77		Allocated from MADO Managem	2010	40,327	1,416	4,237	2,821	5	35,364	77
78										78
79										79
80	TOTALS			\$ 40,327	\$ 1,416	\$ 4,237	\$ 2,821		\$ 40,364	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,531,141	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 56,196	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 103,654	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 47,458	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,827,263	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Margaret Manor

# 0011239

Report Period Beginning: 01/01/13

Ending: 12/31/13

**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	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending	Annual Rent
--------------------	-------------

12. \_\_\_\_\_ /2014 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 4,919

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	<b>TOTAL</b>		\$	\$	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number

Margaret Manor Inc. # 0011239

Report Period Beginning:

1/1/2013 Ending:

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12/31/2013

Supplemental Schedule of Equipment Rental

12/31/2013

	Description	Amount
16A		
16B	Copiers	2,519
16C	Vending Machine	1,104
16D	Ice Machine	1,296
16E		
16F		
16G		
16H		
16I		
16J		
16K		
16L		
16M		
16N		
16O		
16P		
16Q		
	Total	<u>4,919</u>

**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
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**

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

- (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		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)		Total Units (Column 2 + 4)		Total Cost (Col. 3 + 5 + 6)					
			Units of Service	Cost	Units	Cost										
1	Licensed Occupational Therapist		hrs	\$		\$		\$								1
2	Licensed Speech and Language Development Therapist		hrs													2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist		hrs													4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy		# 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):															13
14	<b>TOTAL</b>			\$		\$		\$								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 Margaret Manor# 0011239Report Period Beginning: 01/01/13

Ending:

12/31/13

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 34,705	\$ 73,601	1
2	Cash-Patient Deposits	937	937	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	472,506	472,506	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,931	1,931	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	68,410	68,410	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 578,489	\$ 617,385	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		78,928	13
14	Buildings, at Historical Cost		157,867	14
15	Leasehold Improvements, at Historical Cost	1,935,616	1,935,616	15
16	Equipment, at Historical Cost	459,193	474,193	16
17	Accumulated Depreciation (book methods)	(1,418,131)	(1,590,998)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		31,947	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(14,815)	(20,874)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	4,919,919	16,519,115	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 5,881,782	\$ 17,585,794	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 6,460,271	\$ 18,203,179	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 953,795	\$ 961,296	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	10,591	10,591	30
31	Accrued Taxes Payable (excluding real estate taxes)	858	(693)	31
32	Accrued Real Estate Taxes(Sch.IX-B)		121,238	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>	4,842	4,842	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 970,086	\$ 1,097,274	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	380,000	6,362,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 380,000	\$ 6,362,000	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,350,086	\$ 7,459,274	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 5,110,185	\$ 10,743,905	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 6,460,271	\$ 18,203,179	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

STATE OF ILLINOIS  
# 0011239

Facility Name & ID Number Margaret Manor Inc.  
Supplemental Schedule of Other Assets and Liabilities  
12/31/2013

Report Period Beginning: 1/1/2013 E 12/31/2013

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Other Current Assets		Amount	Amount	Other Current Liabilities:		Amount	Amount
09A	REFUND	1,501		36A	PAT TST FUND	4,440	
09B	EX ACCOUNT	66,120		36B	HEAD TAX PAYABLE	402	
09C	DUE FROM EMPLOYEES	173					
09D	DEPOSIT-PROVIDER FEE	616					
		<u>68,410</u>	<u>0</u>			<u>4,842</u>	<u>0</u>

Other Non-Current Assets:				Other Non Current Liabilities:			
23A	LONG-TERM CARE L.P.	(7,376,430)	7,376,430	43A			
23B	MADO MGMT. L.P.	12,116,808	(1,694,247)	43B			
23C	GOODWILL	4,173		43C			
23D	DAN O'BRIEN	26,035	79,905	43D			
23E	940 CULLOM	(45,000)	2,385,838	43E			
23R	SACRED HEART	65,000	3,497,304	43F			
23G	ST. AGNES HEALTHCARE	54,000	54,000	43G			
23H	ST. MARTHAS	50,000	50,000				
23I	LOAN COST	25,334	25,334				
23J	LTC INC.		34,736				
23K	GEN PARTNERS		13,010			<u>0</u>	<u>0</u>
		<u>4,919,919</u>	<u>11,822,309</u>				
			6,902,390				

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 5,835,641	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 5,835,641	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(725,456)	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (725,456)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 5,110,185	24 *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**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	
<b>I. Revenue</b>		<b>Amount</b>	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,262,298	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,262,298	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	7,615	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	27	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 7,642	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,269,940	30

		2	
<b>II. Expenses</b>		<b>Amount</b>	
<b>A. Operating Expenses</b>			
31	General Services	1,329,930	31
32	Health Care	1,623,989	32
33	General Administration	1,234,140	33
<b>B. Capital Expense</b>			
34	Ownership	615,057	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	8,507	35
36	Provider Participation Fee	183,771	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,995,394	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(725,454)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (725,454)	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 4,192,259	44
45	Private Pay - Net Inpatient Revenue	101,832	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Prior year adjustment</u>	(31,793)	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 4,262,298	49

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

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

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

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

**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name & ID Number Margaret Manor

# 0011239

Report Period Beginning:

01/01/13

Ending:

12/31/13

**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	2,113	2,196	59,535	27.11	3
4	Licensed Practical Nurses	11,241	11,850	279,506	23.59	4
5	CNAs & Orderlies	40,712	44,588	490,786	11.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,917	2,078	29,966	14.42	9
10	Activity Assistants	7,700	8,615	89,329	10.37	10
11	Social Service Workers	7,524	8,170	121,140	14.83	11
12	Dietician					12
13	Food Service Supervisor	7,434	8,136	87,821	10.79	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,166	7,723	76,049	9.85	15
16	Dishwashers	4,214	4,536	50,077	11.04	16
17	Maintenance Workers	8,852	9,565	101,276	10.59	17
18	Housekeepers	12,940	14,494	136,734	9.43	18
19	Laundry	3,584	4,010	38,533	9.61	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,945	3,165	32,014	10.12	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	4,904	5,304	51,128	9.64	31
32	Other Health Care(specify)		(480)	(4,464)	9.30	32
33	Other(specify) <u>Security</u>	12,079	12,785	119,832	9.37	33
34	TOTAL (lines 1 - 33)	135,325	146,735	\$ 1,759,262 *	\$ 11.99	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	MONTHLY	6,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	601	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
45	Social Service Consultant	136	7,903	12-03	45
46	Other(specify)				46
47	<u>Dietary Outside Labor</u>	2,158	37,619	01-03	47
48	<u>Social Service Outside Labor</u>	4,171	99,493	12-03	48
49	TOTAL (lines 35 - 48)	6,477	\$ 151,616		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	7,867	\$ 255,783	10-03	50
51	Licensed Practical Nurses	2,499	68,553	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	10,366	\$ 324,336		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Margaret Manor

#

0011239

Report Period Be

01/01/13

Ending:

12/31/13

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

	<b>1</b> # of Hrs. Actually Worked	<b>2**</b> # of Hrs. Paid and Accrued	<b>3</b> Reporting Period Total Salaries, Wages	<b>4</b> Average Hourly Wage
Labor Improvements-MMNorth		(480.00)	(4,464.00)	9.30



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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Margaret Manor

# 0011239

Report Period Beginning:

01/01/13

Ending:

12/31/13

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. \$ 70 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.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 183,771  
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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. \$ 44,548 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% in 1
  - d. Have vehicle usage logs been maintained? No
  - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? 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.